SWEDISH

Ambulatory Study Questionnaire

INSTRUCTIONS: Please complete this questionnaire after waking up in the morning.

Name: _____ Date of Birth: _____Date: _____ SDC: _____

Test Performed: ☐ ApneaTrak ☐ ApneaLink ☐ Oximetry ☐ ApneaLink Plus

1. Did you have any alcoholic beverages on the day of the test? ☐ Yes ☐ No
   If yes, what time(s) were the beverages consumed? _____

2. Did you take any medication prior to sleeping or during the night? ☐ Yes ☐ No
   If yes, please list medication(s) _____

3. What time did you turn out the lights and attempt to go to sleep last night? _____

4. How long did it take you to fall asleep last night? (please estimate) _____ minutes

5. Did you have any difficulty sleeping? ☐ Yes ☐ No
   If yes, please explain. _____

6. What time did you get out of bed this morning? _____

7. How long did you sleep? (please estimate) _____ hours _____ minutes

8. How deeply do you feel you slept last night? (please rate)
   ☐ Very Deep ☐ Deep ☐ Average ☐ Light ☐ Very Light

9. How did you sleep last night compared to a typical night for you? _____
   _____

10. Where there any unusual circumstances that disturbed your rest or sleep? ☐ Yes ☐ No
    If yes, please explain. _____

11. Did you use any of the **treatment(s)** below last night? (Check all that apply. This does not include testing equipment)
    ☐ CPAP ☐ BiPAP ☐ ASV ☐ Oral appliance (for treatment of sleep apnea) ☐ Provent ☐ O2 ☐ No treatment used

12. Did you use the **treatment(s)** all night? ☐ Yes ☐ No
    If no: What time did you stop the treatment(s)? _____
    Did you also remove the testing equipment? ☐ Yes ☐ No

    Did you have any difficulty with the treatment? ☐ Yes ☐ No
    Please specify: _____

13. Was there any witness to your sleep last night? ☐ Yes ☐ No, I slept alone
    ☐ My bed partner slept well and made no comments ☐ I snored ☐ I had gasping/choking
    ☐ My breathing sounded normal with no snoring ☐ I stopped breathing

14. In what position(s) did you sleep last night? (check all that apply) ☐ Back ☐ Sides ☐ Stomach

Other Comments: _____