



LANDSPÍTALI
HASKÓLASJÚKRAHÚS

Questionnaire for sleep recording

Persónuatriði sjúklings:

Date (dd/mm/yyyy):

Please answer "questions for the evening" in the evening before you go to sleep, and "questions for the morning" when you wake up in the morning. It is important to answer all the questions as well as you can so we can evaluate your health and how your situation affects your sleep tonight.

Questions for the evening:

1. How much sleep did you get last night? Hrs. Min.

2. Was your sleep as usual last night?

☐ Yes ☐ No (if no, then why not)?

3. Did you take a nap during the day?

☐ No ☐ Yes (if yes, then for how long)?

4. How much have you consumed of these items during the past 6 hrs.:

Coffee/tea cups

Cola drinks glasses

Tobacco cigarettes

Alcohol

5. Do you feel any discomfort that may affect your sleep tonight?

☐ No ☐ Yes (if yes, then what is bothering you)?

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BUSV/SSI 91 009

This part is filled out by the staff of Landspítali- University Hospital.

Tæki/herbergi:

Tegund rannsóknar: ☐ Skimun ☐ Innstilling ☐ Eftirlit ☐ Polysomnografía

Staðsetning: ☐ Í heimahúsi ☐ Innliggjandi á lungnadeild ☐ Annars staðar

Fyrsta rannsókn: ☐ Já ☐ Nei

Nætursúrefni: @ L/min.

Öbdunartæki: ☐ CPAP ☐ BiPAP/VPAP ☐ AutoSet ☐ Annað

Tegund vélar Stilling ☐ Rakatæki

Gríma: ☐ Nef ☐ Andlit



Questions for the morning:

1. At what time did you turn off the lights and try to fall asleep?
2. How long did it take you to fall asleep after you turned off the lights? Hrs. Min.
3. How often did you wake up during the night?
4. Did you at some point stay awake for more than 15 min. during the night?
☐ No ☐ Yes (if yes, then for how long)?
5. At what time did you wake up this morning?
6. What was it that woke you up this morning?
☐ I don't know ☐ Noise ☐ Discomfort ☐ Another person ☐ The alarm clock
7. Was there anything that disturbed your sleep last night?
☐ No ☐ Yes (if yes, then what disturbed you)?
☐ Noise
☐ Pain
☐ Anxiety/worries
☐ The bed was uncomfortable
☐ The equipment was uncomfortable
☐ Discomfort because of CPAP/BiPAP/Oxygen
☐ Other
Explain further:
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.....
.....
8. Were all pieces of the equipment in their right place when you woke up this morning?
☐ Yes ☐ No (if no, then which ones were loose)?
9. Did you take any drugs to help you sleep last night?
☐ No ☐ Yes (if yes, then which drugs did you take)?
10. How soon did you fall asleep compared to a normal night?
☐ Much later ☐ Somewhat later ☐ As usual ☐ Sooner ☐ Much sooner
11. How often did you wake up compared to a normal night?
☐ Much more often ☐ More often ☐ As usual ☐ Fewer times than usual ☐ A lot less than usual
12. When did you wake up this morning compared to a normal morning?
☐ Much earlier ☐ Somewhat earlier ☐ At the usual time ☐ Later ☐ Much later
13. How did you sleep compared to a normal night?
☐ A lot worse ☐ Worse ☐ As usual ☐ Better ☐ Much better
14. How rested are you from your sleep compared to a normal morning?
☐ A lot less rested ☐ Somewhat less rested ☐ As usual ☐ More rested ☐ Much more rested