
Morning questionnaire

Instructions

- Please mark all answers clearly
 - If the question is multiple choice, mark your answer by placing an x in the box:
 - If there are no response alternatives listed, write in your response in the provided space
-

1. **Current date:** _____ **Current time:** _____

2. **In the 6 hours before you went to bed did you drink any alcohol?**

- Yes
 No

3. **In the 6 hours before you went to bed did you drink any caffeine (e.g. coffee, tea, soda)?**

- Yes
 No

4. **In the 6 hours before you went to bed did you use any medications or supplements (herbal or otherwise)?**

- Yes. If yes, please list the medication and/or supplements used: _____

- No

5. **Thinking about yesterday, how stressful was your day?**

- Not at all Slightly Moderately Very Extremely

6. **Last night, did you sleep with the windows...**

- Closed
 Partially open
 Completely open

7. **Last night, did somebody share the bed with you (e.g. partner, child, pet)?**

- Yes
 No

8. At what time did you...

go to bed and switch off the light last night? _____ (Hour: Minute)

wake up this morning? _____ (Hour: Minute)

get out of bed this morning? _____ (Hour: Minute)

9. How long did it take you to fall asleep after you turned the lights off?

_____ (minutes)

10. Did you wake up during the night?

Yes

No

If so, how many times? _____

What were the reasons, please describe: _____

11. How do you feel right now?

Very refreshed
and rested

Refreshed and
rested

Neither refreshed
nor tired

Tired

Very tired

12. Please check the box next to the statement that best describes how sleepy you feel right now...

Extremely alert

Very alert

Alert

Rather alert

Neither alert nor sleepy

Some signs of sleepiness

Sleepy, but no effort to keep awake

Sleepy, some effort to keep awake

Very sleepy, great effort to keep awake, fighting sleep

13. Thinking about last night, how would you rate your sleep quality overall?

- | | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Very good | Fairly good | Neither good
nor bad | Fairly bad | Very bad |

14. Thinking about last night, how much did noise from aircraft disturb your sleep?

- | | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Not at all | Slightly | Moderately | Very | Extremely |

15. Other comments?

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If you have any questions or concerns please call us at 555-555-5555