ID:_____ Date:_____

Instructions: This scale is designed to record your assessment of any sleep difficulty you might have experienced. Please complete this scale before, and 1,3, and 7 days after the examination. All scales will be finally e-mailed to the designated anesthesiologist.

	0	**1**	**2**	**3**
1. Sleep induction (the time it takes you to fall asleep after turning off the lights)	No problem	Slightly delayed	Markedly delayed	Very delayed or did not sleep at all
2. Awakenings during the night	No problem	Minor problem	Considerable problem	Serious problem or did not sleep at all
3. Final awakening earlier than desired	Not earlier	A little earlier	Markedly earlier	Much earlier or did not sleep at all
4. Total sleep duration	Sufficient	Slightly insufficient	Markedly insufficient	Very insufficient or did not sleep at all
5. Overall quality of sleep (no matter how long you slept)	Satisfactory	Slightly unsatisfactory	Markedly unsatisfactory	Very unsatisfactory or did not sleep at all
6. Sense of well-being during the day	Normal	Slightly decreased	Markedly decreased	Very decreased
7. Functioning (physical and mental) during the day	Normal	Slightly decreased	Markedly decreased	Very decreased
8. Sleepiness	None	Mild	Considerable	Intense

during the day				