Supplementary Table 1.

Example Questions post sleep study questionnaire

Name: Date of Birth:

In brief, what is your main sleep complaint?			
Did you experience this during your sleep study?	Yes	No	Don't remember
How did you sleep compared to a normal night at home?	Worse than normal	About the same	Better than normal
How long do you think it took to fall asleep?			
Did you experience a typical event during the sleep study?	Yes	No	Don't remember
Do you think it was a dream?	Yes	No	Don't remember
Did you see anything (e.g. animals, insects, people, shadows)?	Yes	No	Don't remember
Did they change in shape, move or did you feel threatened by them?	Yes	No	Don't remember
Did you feel, smell or taste anything?	Yes	No	Don't remember
If you had an event, do you remember how you were feeling (e.g. anxious, frightened, hot)?			
Do you have any further comments regarding your study?			