Questionnaire to Fill Out:

**Survey before going to bed:**

Did you do exercise today? No

When did you have dinner? 3 hours ago

Did you have sex today? No

In the last X hours did you: (select all that apply)

Drink alcohol No

Smoke No

Drink coffee Yes

Do you sleep naked? No

In the last hour did you drink water? Yes

Do you sleep with electronic devices turned on in you room? Yes

Do you feel tired? Yes

**Survey after getting out of bed:**

Did you wake up to: natural light

Did you wake up to urinate during the night? No

Did you turn the lights on during the night? No

Did any electronic device wake you up? Yes

Do you feel tired? Yes

Overall, do you feel like you had a good sleep? No