

SUPPLEMENTARY MATERIALS

Questionnaire for patients with sleep and mood disorders

Name		Age	
Sex		Home address	
Date of COVID-19 infection		Recovered or not	
Insomnia or not (difficulty falling asleep, increased awakenings, early awakenings, multiple dreams, nightmares, etc.)		Time to start insomnia	
Bad mood or not (irritable, depressed, etc.)		Time to be in a bad mood	
Date of hospital visiting		Date of sleep monitoring	
		Date of the scale assessment	