Date: _____

1st Night **2nd Night**
(Please circle one.)

Pre-Sleep Questionnaire

PATIENT NAME _____

What time did you go to bed last night? ____:____ o AM o PM

What time did you get up? ____:____ o AM o PM

About how many hours of sleep did you get last night? _____

Did you take any naps today? Yes / No If yes, how long? _____ mins / hours

Will you be taking a sleep aide tonight? Yes / No If yes, please list: _____

Have you had any alcoholic beverages today? Yes / No If yes, what? _____

Have you had any caffeinated beverages today? Yes / No If yes, what? _____

Have you smoked today? Yes / No

Have you felt sick or had physical complaints today? Yes / No If yes, what?_____

Do you feel better now? Yes / No / Partially

Did anything out of the ordinary happen today? Yes / No If yes, what? _____

Did you have a physically strenuous day? Yes / No

What time did you eat your last meal? _____:_____ o AM o PM

How tired do you feel right now? o Not at all o A little o Quite a bit o Extremely

How sleepy do you feel right now? o Not at all o A little o Quite a bit o Extremely

How awake, or alert, do you feel right now? o Not at all o A little o Quite a bit o Extremely

Comments: _____

What time are you starting your home sleep study tonight? _____:_____ o AM o PM