

Sleep Smart

PRE-TEST QUESTIONNAIRE

Date _____

Name _____ D.O.B. _____ Age _____

♂ Male ♀ Female Height _____ Weight _____

Section I

Medical History: ♂ High Blood Pressure ♂ Bypass Surgery ♂ Heart Attack
♂ Congestive Heart Failure ♂ Asthma ♂ Stroke
♂ Hiatal Hernia/Reflux ♂ COPD (emphysema, bronchitis)
♂ Diabetes ♂ Other _____

Reason for Study: (list symptoms) _____

Medications: _____

Recent change in weight: _____

When is your average bedtime? _____ AM/PM Wake up time? _____ AM/PM

On an average night: How long does it take to fall asleep? _____

How many hours do you spend in bed? _____

How many hours do you sleep at night? _____

Number of awakenings? _____ Length of awakenings? _____

SECTION II

Bedtime last night _____ Wake up time today _____

Estimated number of hours slept _____

Did you nap today? Yes No If so, when? _____

For how long? _____

How many caffeinated beverages a day do you drink on average? _____

Coffee	_____ # Cups	When: _____
Tea	_____ # Cups	When: _____
Cola	_____ # Cups	When: _____
Other	_____ # Cups	When: _____

Do you usually drink alcohol each day? Yes No

Did you drink alcohol today/tonight? Yes No

If yes:

Beer	_____ # ounces	When: _____
Wine	_____ # ounces	When: _____
Liquor	_____ # ounces	When: _____
Mixed Drinks	_____ # ounces	When: _____

Sleep studies typically end between 5:00 a.m. and 5:30 a.m.

Would you like to be awakened at a certain time prior to this? Yes No

If yes, what time? _____