

**PATIENT SUBJECTIVE OBSERVATIONS
PRE-SLEEP QUESTIONNAIRE**

Technician: _____

PATIENT NAME: _____

STUDY DATE: _____

1. How many hours did you feel that you slept last night? ___Hours ___Minutes
2. Do you feel this amount of sleep was adequate? Yes No Specify
3. Did you nap today? (If yes, how many naps and how long?) Yes No
4. What time did you eat last? a.m. p.m.
5. Did you consume alcohol today? If yes, note quantity and time below.
 Yes No ___Ounces ___ Cans ___ Bottles
6. Did you consume caffeine today?
 Yes No ___ Cups ___ Cans
7. Do you have any physical complaints right now? (If yes, explain.) Yes No
8. How do you feel right now?
 Very alert Alert Sleepy Very Sleepy
9. Has anything changed since your last sleep study, i.e. weight gain/loss or medications?

List all the medications that you are currently taking or check one none

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