McLAREN FLINT
SLEEP DIAGNOSTIC CENTER
PATIENT PRE-SLEEP STUDY QUESTIONNAIRE

Name: _____ Date: _____ / _____ / _____

1. **Have you had any of the following during the last 24 hours?** (list type, amount and time)

   Alcohol: ❑ Yes ❑ No Amount: _____ At: _____ a.m. / p.m.

   Coffee/Tea: ❑ Yes ❑ No Amount: _____ At: _____ a.m. / p.m.

   Chocolate: ❑ Yes ❑ No Amount: _____ At: _____ a.m. / p.m.

   Medication that you don't take daily: Type: _____ At: _____ a.m. / p.m.

2. **Was last night's sleep typical for you regarding total sleep time, awakenings and quality?** ❑ Yes ❑ No

   Please explain: _____

   _____

3. **Did you nap today?** ❑ Yes ❑ No For how long: _____

4. **How stressful was your day?** ❑ Not at all ❑ A little stressful ❑ Very stressful

5. **How does this compare with a usual day for you?** ❑ Less stressful ❑ The same ❑ More stressful

6. **How nervous are you about this study?** ❑ Not at all ❑ Slightly nervous ❑ Very nervous

7. **How do you feel right now?**

   Physically fatigued: ❑ Not at all ❑ A little ❑ Quite a bit ❑ Extremely

   Sleepy: ❑ Not at all ❑ A little ❑ Quite a bit ❑ Extremely

   Alert: ❑ Not at all ❑ A little ❑ Quite a bit ❑ Extremely

8. **Who recognized your sleep problem?** ❑ Self ❑ Bed partner ❑ Physician ❑ Other: _____

9. **Are you currently experiencing any pain or discomfort?** ❑ Yes ❑ No

   If yes, explain: _____

   _____

10. **What is your normal bedtime?** _____ a.m. / p.m.

11. **Wake times begin around 6:00 am, is there a specific time you need to be awakened?**

    ❑ Yes Time requested: _____ a.m. / p.m.

PATIENT
PRE-SLEEP STUDY
QUESTIONNAIRE

M-17030 (6/14)

415b

PT.

MR.#/P.M.

DR.