Pre-Sleep Study Questionnaire

Name: ______________________ **Date:** ______________ **Time Completed:** ____________

Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired?

Choose the number that most appropriately applies to each situation:

0 – Would Never Doze 1 – Slight Chance of Dozing 2 – Moderate Chance of Dozing 3 – High Chance of Dozing

Sitting and reading.	________	Lying down to rest in the afternoon.	________
Watching television.	________	Sitting and talking to someone.	________
Sitting inactively in a public place.	________	Sitting quietly after lunch without alcohol.	________
As a passenger in a car for about an hour.	________	In a car while stopped for a few minutes.	________
		Total:	________

Last Night's Bedtime: __________ Wake-up Time Today: __________ Was this adequate? ☐ YES ☐ NO

Did you take a nap today? ☐ YES ☐ NO What time? How Long? Was it refreshing? ☐ YES ☐ NO

Medications Taken Today: ______________________________

Do you have any of the following on an ***Average Day***?

☐ Coffee	How Much?	________	What Time?	________	☐ am	☐ pm
☐ Tea	How Much?	________	What Time?	________	☐ am	☐ pm
☐ Cola	How Much?	________	What Time?	________	☐ am	☐ pm
☐ Chocolate	How Much?	________	What Time?	________	☐ am	☐ pm
☐ Alcohol ________	How Much?	________	What Time?	________	☐ am	☐ pm

Did you have any of the following ***Today*** or ***Tonight***?

☐ Coffee	How Much?	________	What Time?	________	☐ am	☐ pm
☐ Tea	How Much?	________	What Time?	________	☐ am	☐ pm
☐ Cola	How Much?	________	What Time?	________	☐ am	☐ pm
☐ Chocolate	How Much?	________	What Time?	________	☐ am	☐ pm
☐ Alcohol ________	How Much?	________	What Time?	________	☐ am	☐ pm

Exercise Regularly? ☐ YES ☐ NO Today? ☐ YES ☐ NO What Time? ________ ☐ am ☐ pm

Do you have any pain or physical complaints right now? ☐ YES ☐ NO If yes, please describe in detail below:

____

Rate pain on 0 – 10 scale with 0 = None and 10 = Worst: ________ Pain Location: ______________

Has today been an unusual day in any way? ☐ YES ☐ NO If yes, please explain below:

____

Choose the statement that best describes how you feel right now.

☐ Alert and wide awake.	☐ Functioning at high level but not at peak.
☐ Awake but not at full alertness.	☐ Responsive but not fully awake.
☐ A little foggy and woozy.	☐ Sleepy, prefer to lie back down.
☐ Fighting sleep.	☐ Losing struggle to remain awake.

The technologist will allow you to sleep for 6 - 7 hours from Lights Out or until at least 5:00 am.

Would you like to be awakened at a certain time prior to this? ☐ YES ☐ NO If yes, what time? ________

Please list any special needs: ______________________________

MEHCG, PA © 2009