ENTERPRISE
SLEEP & DIAGNOSTICS

Pre-Sleep Questionnaire

Patient: _____ **DOB:** _____

Date: _____ **Study Number**_____

1. **How many hours of sleep do you feel you had last night?** _____
2. **Do you feel you slept well last night?** _____**Yes** _____**No**
   If not, explain:
   _____
   _____
3. **Have you taken any naps today?** _____**Yes** _____**No**
   If yes, at what time and how long did you sleep? _____
4. **Have you taken any medication this week?** _____**Yes** _____**No**
   If so, what medication, when and how long have you been taking it?
   _____
   _____
5. **Have you had any caffeinated beverages today?** _____**Yes** _____**No**
   If so, what beverage, how much and what time did you have it?
   _____
   _____
6. **Have you had any alcoholic beverages today?** _____**Yes** _____**No**
   If so, what beverage, how much and at what time did you have it?
   _____
   _____
7. **Have you felt ill today or do you feel ill now?** _____**Yes** _____**No**
8. **Did you feel sleepy today?** _____**Yes** _____**No**
   If so, when:_____
9. **Did you have a physically strenuous day today?** _____**Yes** _____**No**
10. **What time did you eat your last meal?** _____
11. **How tired do you feel right now?**

    ☐**Not at all** ☐**A little** ☐**Quite a bit** ☐ **Extremely**

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