Colorado Springs Health Partners Sleep Center
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PRE-SLEEP STUDY QUESTIONNAIRE

Name: _____ **Date of Study:** _____

Please respond to the following questions as accurately as possible.

1. How many hours did you sleep last night? _____ hours

2. Did you feel rested upon awakening this morning? ❒ Yes ❒ No

3. Do you normally nap during the day? ❒ Yes ❒ No

4. On average, how much caffeine do you consume a day?

Coffee _____ cups/day Tea _____ cups/day Soda _____ cans/day

5. Are you sensitive or allergic to any types of tapes or adhesives? ❒ Yes ❒ No

If yes, please explain: _____

6. Do you take sleep aides to help you go to sleep? ❒ Yes ❒ No

If yes, what? _____

7. Do you take any medications to help you stay awake? ❒ Yes ❒ No

If yes, what? _____

8. If you suffer from body pain that keeps you from sleeping, please describe:

_____

9. Do outside noises keep you from falling asleep? ❒ Yes ❒ No

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

❒ Alert and wide awake

❒ Tired, but able to concentrate; could go to sleep

❒ Having difficulty staying awake; fighting sleep

11. Please give us any feedback about scheduling your appointment and feeling prepared for the study:

_____

_____

Thank You!

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