

Colorado Springs Health Partners Sleep Center 1625 Medical Center Point, Suite 290 Colorado Springs, CO. 80907

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PRE-SLEEP STUDY QUESTIONNAIRE

e	respond to the following questions as accurately as poss	ible.			
<u>1.</u>	How many hours did you sleep last night? h	ours			
<u>2.</u>	Did you feel rested upon awakening this morning?	☐ Yes		□ No	
<u>3.</u>	Do you normally nap during the day?	☐ Yes		□ No	
<u>4.</u>	On average, how much caffeine do you consume a day?				
	Coffee cups/day Tea cup	s/day	Soda _		cans/day
<u>5.</u>	Are you sensitive or allergic to any types of tapes or adhe	sives?	☐ Yes		□ No
	If yes, please explain:				
<u>6.</u>	Do you take sleep aides to help you go to sleep?	☐ Yes		□ No	
	If yes, what?				
<u>7.</u>	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				
<u>9.</u>	Do outside noises keep you from falling asleep?	☐ Yes		□ No	
<u>10</u>	. Choose the statement below that best describes how you	ı feel rigl	ht now:		
	☐ Alert and wide awake				
	☐ Tired, but able to concentrate; could go to sleep				
	☐ Having difficulty staying awake; fighting sleep				
	Please give us any feedback about scheduling your appoir	ntment a	and faali	ng nrer	ared for the