Sleep Center
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DaVita Medical Group

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!