



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.

Optum® is a trademark of Optum, Inc. All other trademarks are the property of their respective owners. Because we are continuously improving our products and services, Optum reserves the right to change specifications without prior notice. Optum is an equal opportunity employer.