CARLOS R. SANTOS MD., PA
SLEEP DIAGNOSTIC CENTER

PRE – SLEEP QUESTIONNAIRE

NAME: _____ DATE: _____AGE: _____
WEIGHT: _____ HEIGHT: _____

Have you ever had a sleep study before? ( ) **Yes** ( ) **No**
If yes, approximately when?
_____
_____

Are you currently on CPAP or Bi-PAP ( ) **Yes** ( ) **No**

Do you currently use a dental appliance for sleep? ( ) **Yes** ( ) **No**

How many hours did you sleep last night? _____

What time did you go to sleep? _____

What time did you wake up? _____

Did you nap today? ( ) **Yes** ( ) **No**
If yes, what time? _____ and for how long? _____

Have you had any caffeine (pop, coffee, ice tea) today? ( ) **Yes** ( ) **No**
If yes, how many cups/oz.? _____
When was your last caffeinated drink? _____

FOR ADULTS:

Have you had any alcohol today? ( ) **Yes** ( ) **No**
If yes, how many drinks and what type? _____
When was your last alcoholic drink today? _____

Do you feel upset or anxious today? ( ) **Yes** ( ) **No**
If yes, why?
_____
_____

How sleepy are you right now? (Circle Best)

Not at all A little sleepy Very Sleepy

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