EZ Sleep Club
SLEEP DIAGNOSTIC CENTER

PRE-SLEEP QUESTIONNAIRE

Patient Name | Date of Birth | Today's Date

How much sleep did you get last night? _____ Hours

What time did you awaken this morning? ____ a.m./p.m.

Did you take any naps today? ☐ Yes ☐ No

Have you had any of the following today? ☐ Coffee ☐ Tea/Soft Drinks ☐ Alcohol ☐ Nicotine

Has anything out of the ordinary happened recently?

Did you do any strenuous activity today?

Do you have any physical complaints right now?

How tired are you right now?

☐ Not at all ☐ A little ☐ Quite a lot ☐ Extremely