

Sleep Medicine Services of Western Massachusetts

PRE-STUDY QUESTIONNAIRE

Name: _____ Date of Birth: _____ Date of Study: _____

Primary Care Physician (Doctor/Nurse Practitioner): _____

Other Provider/Physician you would like to Receive Your Test Results: _____

I am having this sleep study performed because of (please select one or more of the following):

- | | |
|--|---|
| <input type="checkbox"/> Excessive fatigue/sleepiness | <input type="checkbox"/> Insomnia (difficulty sleeping) |
| <input type="checkbox"/> Snoring | <input type="checkbox"/> Leg jerks when I sleep |
| <input type="checkbox"/> Stopping breathing during sleep | <input type="checkbox"/> Other: _____ |

My height is: _____ My weight is: _____ Are you allergic to latex? Yes No

Are you concerned with falling during the night? Yes No

My usual working/school hours are: _____ AM/PM to _____ AM/PM (I am not currently working)

On days I am not working/in school...

...I go to bed at _____ AM/PM.

...I get up at _____ AM/PM.

On work-days/school days...

...I go to bed at _____ AM/PM.

...I get up at _____ AM/PM.

Last night, I slept from _____ AM/PM to _____ AM/PM

Today, I napped from _____ AM/PM to _____ AM/PM

Today, I have had --

- | | | |
|--|---|--|
| <input type="checkbox"/> Caffeinated beverages | <input type="checkbox"/> Other stimulants | <input type="checkbox"/> Tranquilizers |
| <input type="checkbox"/> Acoholic beverages | <input type="checkbox"/> Marijuana | <input type="checkbox"/> None of these |

In the past 2 weeks, I've used the following medications (Please write "None", if applicable)

(For technicians' use): Patient's BMI: _____ Patient's neck circumference: _____ inches ESS _____

Set-Up Technician _____ Recording Technician _____