Piedmont Internal Medicine, Pulmonary And

Infectious Diseases, PA.

Pre-Sleep Questionnaire

Patient Name: _____ **Date:** _____

Time of last meal:_____

1. Did anything unusually stressful occur to you today? _____
2. Did you have what you consider a normal night's sleep last night? _____
3. Did you take any naps today? _____
4. If so, at what time and for how long? _____
5. Have you consumed any alcohol today, if yes how much? _____
6. How tired/sleepy do you feel right now?
    a. Not at All
    b. Somewhat
    c. Very
    d. Extremely
7. How alert do you feel right now?
    a. Not at All
    b. Somewhat
    c. Very
    d. Extremely
8. Are you claustrophobic?
    a. Yes
    b. No
10. If yes to the above question, to what severity are you claustrophobic?
    a. Mildly
    b. Moderately
    c. Severely

Using the scale below, rate how likely you are to doze or fall asleep in situations listed below:

0 = no chance of dozing/falling asleep
1 = slight chance of dozing/falling asleep
2 = moderate chance of dozing/falling asleep
3 = high chance of dozing/falling asleep

SITUATION:

____ Sitting and reading a magazine or book
____ Watching television
____ Sitting inactive in a public place (e.g. A meeting, or in a theater)
____ As a passenger in a car without a break for an hour
____ Lying down to relax
____ Sitting while talking to someone
____ Sitting quietly after lunch without alcohol
____ In a car, while stopped for a few minutes in traffic

Total: ____