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):

- ☐ Excessive fatigue/sleepiness
- ☐ Insomnia (difficulty sleeping)
- ☐ Snoring
- ☐ Leg jerks when I sleep
- ☐ Stopping breathing during sleep
- ☐ 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 --

- ☐ Caffeinated beverages
- ☐ Other stimulants
- ☐ Tranquilizers
- ☐ Acoholic beverages
- ☐ Marijuana
- ☐ None of these

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

NAME	TIME OF LAST DOSE	NAME	TIME OF LAST DOSE

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

Set-Up Technician_____ **Recording Technician**_____