Infinity Sleep Solutions

"A Better Night's Sleep"

Patient Name: _____ DOB: ____/_____/_____

Pre-Sleep Questionnaire

PLEASE COMPLETE THIS FORM ON THE DAY OF YOUR STUDY

What time did you go to bed last night? _____ AM / PM

What time did you wake today? _____AM / PM

How many hours of sleep do you feel you achieved last night? _____

Did you take naps during the day today? Yes or No
If yes, what time and for how long? _____

Did you drink any alcoholic beverages today? Yes or No

If yes, how many? _____when?_____

Did you drink any caffeinated beverages today? Yes or No

If yes, how many? _____when?_____

How do you feel right now? Sleepy / Alert but tired / Wide awake

What medications have you taken or will you be taking today?

☐ Same as listed on the Patient Questionnaire

☐ Different than what is listed on the Patient Questionnaire. Please list below.

_____

_____

_____

_____