1. Did you take any naps today? ❑ Yes ❑ No
   If yes, at what times and how long: _____

2. List the prescription and over-the-counter medications you have taken in the last 72 hours:

Medication	Dosage	Medication	Dosage

3. Did you have any alcoholic beverages today? ❑ Yes ❑ No
   If yes, what: _____
   When: _____ How much: _____

4. Have you felt ill today? ❑ Yes ❑ No
   If yes, please explain: _____

5. Did anything out of the ordinary happen today? ❑ Yes ❑ No
   If yes, explain: _____

6 Did you feel sleepy today? ❑ Yes ❑ No
   If yes, when: _____

7. Did you have a physically strenuous day? ❑ Yes ❑ No
   If yes, explain: _____

8. What time did you eat your last meal? _____

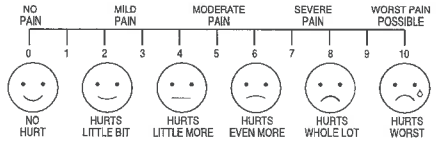
9. Compared to usual, was that meal:
   ❑ Less ❑ Same ❑ More than normal

10. How tired do you feel now?
    ❑ Not at all ❑ A little ❑ Quite a bit ❑ Extremely

11. How sleepy do you feel now?
    ❑ Not at all ❑ A little ❑ Quite a bit ❑ Extremely

12. How alert do you feel now?
    ❑ Not at all ❑ A little ❑ Quite a bit ❑ Extremely

13. Please circle any pain you may be experiencing right now:



Comments

_____

_____

Patient Signature	Date	Time
Technologist Signature	Date	Time

Pre-Sleep Questionnaire
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Patient Label