

PATIENT PRE-STUDY QUESTIONNAIRE

Patient Name: \_\_\_\_\_ Date of Study: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Social Security # \_\_\_\_\_

1. Have you taken any medications today/tonight?  Yes  No

If yes, please specify what and when: \_\_\_\_\_

\_\_\_\_\_

2. List all medications taken in the past week: \_\_\_\_\_

\_\_\_\_\_

3. Do you smoke?  Yes  No

If yes, how many cigarettes per day? \_\_\_\_\_

4. Have you had any beverages containing Caffeine today?  Yes  No

If yes, please specify what and when: \_\_\_\_\_

\_\_\_\_\_

5. Have you had any alcoholic beverages today/tonight?  Yes  No

If yes, please specify what and when: \_\_\_\_\_

\_\_\_\_\_

6. How did you sleep last night? \_\_\_\_\_

\_\_\_\_\_

Please specify what time went to bed: \_\_\_\_\_

Time awoke this morning: \_\_\_\_\_

7. Compared to the usual, did you get last night:  
 less sleep       same sleep       more sleep

8. Have you felt tired today/tonight?  Yes  No

9. Did you take any naps today/tonight?  Yes  No

10. Do you usually take naps?  Yes  No

11. Has anything unusual happened to you today?  Yes  No

If yes, please explain: \_\_\_\_\_

\_\_\_\_\_

12. Did you eat dinner tonight?  Yes  No

If yes, what time? \_\_\_\_\_

\_\_\_\_\_