PACIFIC SLEEP
PROGRAM

HOME SLEEP STUDY QUESTIONNAIRE

Name: _____ **D.O.B**____/____/____

Height: _____**Weight:** _____ **Neck:** _____ **Scoring:** _____ **Bedtime:** _____

BEDTIME QUESTIONNAIRE

1. Have you had any alcohol today? ❑ Yes ❑ No

   If yes, how many drinks did you have prior to the study? _____drinks

   If yes, is this your typical alcohol intake? ❑ Yes ❑ No

2. Will you be taking any medications for sleep tonight? ❑ Yes ❑ No

   If yes, which medications? _____

MORNING QUESTIONNAIRE

1. How long did it take you to fall asleep last night? _____Hours _____Minutes

2. How long do you feel you slept last night? _____Hours _____Minutes

3. Other than the fact that you were wearing a testing device, do you feel this was a typical night of sleep for you?

   ❑ Yes ❑ No

   If no, please explain: _____

   _____

4. If you were told to hold PAP (positive airway pressure) therapy before the study, how many days did you sleep without PAP therapy prior to testing? _____Days

5. Did you use positional therapy last night? ❑ Yes ❑ No

   If so, which one? (e.g.: Night Shift, ZZoma, self-made device, etc.) _____

6. Did you use an oral appliance for treatment of sleep apnea last night? ❑ Yes ❑ No

*****Please return this questionnaire with the home sleep study equipment*****