SOUTHWEST PULMONARY & SLEEP CENTRE

Suite 2.12 (Level 2) TRN House
90 Podium Way Oran Park NSW 2570
P (02) 4607 5010
F (02) 4607 5011
E reception@swcpc.com.au

Pre-Sleep Patient Questionnaire

To be answered the **night of** your sleep test and will be assessed by the sleep physician.

Patient Name: _____Date of Study: _____Patient Chart #_____

1. What time did you go to bed last night? _____ AM/PM (circle one)
2. How long did it take you to fall asleep last night? _____ Minutes
3. How many hours of sleep did you get last night? _____ Hours
4. What time did you get up today? _____ AM/PM (circle one)

During the day today, did you?	**Check one**	**If yes, please explain**
Take any **naps?**	☐ Yes ☐ No	What time? AM/ PM How Long? _____ Minutes
Drink any **Coffee, Tea** or **Cola?**	☐ Yes ☐ No	What? _____ How much? _____ What time? _____
Drink any **alcohol?**	☐ Yes ☐ No	What? _____ How much? _____ What time? _____
Take any **medications?**	☐ Yes ☐ No	What? _____ How much? _____ What time? _____ What for? _____
Did you do anything **physically strenuous?**	☐ Yes ☐ No	What? _____ What time? _____ AM/PM
Did you have anything **unusual happen?**	☐ Yes ☐ No	What? _____ What time? _____ AM/PM

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Post-Sleep Questionnaire

To be answered the morning **after** your sleep test and will be assessed by the sleep physician.

Patient Name: _____Date of Study: _____ Patient Chart #_____

1. How long did it take you to get to sleep last night? _____ Minutes
2. Did you wake up during the night?
   - ☐ Yes
   - ☐ No

If yes, how many times did you wake up last night? _____ Times

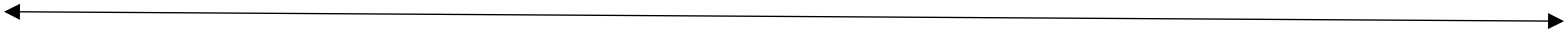
If yes, what woke you up? _____

3. How many hours of sleep did you get last night? _____ Hours
4. How well did you sleep last night? (Please check one)
   - ☐ Much worse
   - ☐ Worse
   - ☐ About the same
   - ☐ Better
   - ☐ Much Better

Please use the following scale to answer questions 5 through 8

1= Not at all **2=** Somewhat **3=** Average **4=** Very **5=** Extremely

5. How refreshing was your sleep last night? _____
6. How restless was your sleep last night? _____
7. How difficult was it to fall asleep last night? _____
8. How rested do you feel this morning? _____
9. Please place a mark on the scale below which describes your sleepiness right now



Very Sleepy **Completely awake**

10. Is there anything else about the sleep study you would like to mention regarding your sleep?

_____
_____
_____