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Pre-Sleep Questionnaire

Patient Name:		DOB:
Do you feel today has been an If yes, please explain	• — —	
How much sleep did you have	e last night?Hours	5
Did you take a nap today? If yes, how long was your nap		
Approximately what time was	s your last full meal?	
Did you drink any caffeine or If yes, list type, amount, and t	· -	•
How are you feeling now? ☐ Alert and wide awake ☐ Relax	ted and awake A little fogg	y, not great Sleepy, ready for bed
List any medications you have	e taken today? (Include O	TC or prescription)
Medication Name	Amount/Dose	Approximate Time Taken
Any physical complaints?		