First Coast Cardiovascular Institute  
Sleep Disorders Center  

PRE-TEST SCREENING  

Name: ___________________________  
MR#: ___________________  
Date: ________________  

Height: ____ft   ____ in  
Weight: ______lbs  
Neck size: ___________  

(Please circle/fill in the blank for the correct answer)  

1. Did you take any naps today?  
Yes  No  

2. Have you taken any medications today?  
Yes No  
If so, which medications? (Please list them below)  
________________________________ _________________________________  
________________________________ _________________________________  

3. Are you currently on oxygen?  
Yes No  

4. What time do you normally go to bed? _______ p.m.  

5. What time do you get up? _______ a.m.  

6. How long does it normally take you to go to sleep? _______  

7. Do you sleep with the T.V. on?  
Yes No  

8. Do you take medications to make you sleep?  
Yes No  

9. Do you have difficulty falling asleep?  
Yes No  

10. Have you had any alcoholic beverages today?  
Yes No  

11. Have you felt sick today or do you feel sick now?  
Yes No  
If yes, please explain: _____________________________________  

12. Has anything out of the ordinary happened today?  
Yes No  
If yes, please explain: ________________________________  

13. Did you have difficulty staying awake today?  
Yes No  

14. What time did you eat last? ________ A.M. or P.M.  

15. What time did you last have caffeine? ________ A.M. or P.M.  

16. Could you fall asleep now if you got into bed?  
Yes No  

17. Do you feel tired or fatigued right now?  
Yes No  

18. How alert do you feel right now?  
A little bit  quite a bit  extremely  

19. Have you ever had a sleep study before?  
Yes No  
If so, where? _____________________  

20. What physicians are to receive a copy of this sleep study?  
Dr. __________________________