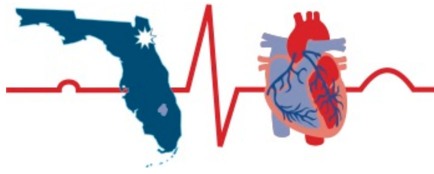

First Coast Cardiovascular Institute
Sleep Disorders Center

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. ________________________________