

BOICE SLEEP LABORATORY  
NAVAL MEDICAL CENTER PORTSMOUTH

Date \_\_\_\_\_  
Name \_\_\_\_\_ SSN- \_\_\_\_\_ DOB: \_\_\_\_\_

PRE TEST QUESTIONNAIRE

*Please answer the following 4 questions on the day of your test:*

Have you napped today Y / N  
Has today been unusual for you in any respect N / Y, if yes, how?  
\_\_\_\_\_

List your bedtimes and rise times for each of the past 7 days as best you can:

	BEDTIME	RISETIME	
1)	_____	_____	Has this been a typical week of sleep for you?  Y / N
2)	_____	_____	
3)	_____	_____	
4)	_____	_____	
5)	_____	_____	
6)	_____	_____	
7)	_____	_____	

---

POST TEST QUESTIONNAIRE

*Please answer the following 4 questions after completing your test. Return this questionnaire to the sleep lab when you return your equipment:*

How long were you in bed? \_\_\_\_\_  
How many hours did you sleep? \_\_\_\_\_

Aside from the novelty of wearing the sleep equipment, how would you rate your sleep last night compared to your normal night?  
Circle one:

Much worse than usual      Worse than usual      Same as usual      Better than usual      Much better than usual

Do you have any additional comments or facts about your sleep history that you would like the physician reading this sleep study to consider?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Thank you for your time and attention in completing these forms. The information you have provided will be used in conjunction with the recording data to generate a diagnosis of you sleep condition.