

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. (This part should be blank when you arrive at the lab - you'll fill it out later).

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.