Family In-Lab Pre-Sleep Study
(To be orally administered before sleep.)

Patient ID _____

Lab Study Date ___/___/___

Pre-Sleep Questionnaire:

1. Have you ingested any caffeinated beverages (cola, coffee, tea) after 5 p.m. this evening? _____ (0) No _____ (1)Yes
lcafbev

If yes,

Beverage	Quantity (# of 8oz cups)	Time (pm)
lcafbv1 _____	lcafbv1q _____	_____ lcafbv1t
lcafbv2 _____	lcafbv2q _____	_____ lcafbv2t
lcafbv3	lcafbv3q	lcafbv3t

2. Have you taken any naps today? _____ (0) No _____ (1)Yes
napdy

If yes,

Length of nap (hrs/min)		Time (indicate am/pm)	
napdy1h ____/_____	napdy1m	_____	napdy1t
napdy2h ____/_____	napdy2m	_____	napdy2t
napdy3h	napdy3m		napdy3t

3. Have you taken any medication (prescribed or over-the-counter) today? _____ (0) No _____ (1)Yes lanymed

If yes,

Medication name:	No	Yes ™	**If yes**, time (am/pm)
lseds 1) Sedatives (Tranquilizers)	☐	☐	_____
lstim 2) Stimulants (Ritalin)	☐	☐	_____
lanti 3) Antihistamines	☐	☐	_____
lbron 4) Bronchodilators (Asthma Meds or Sprays)	☐	☐	_____
lsplpil 5) Sleeping Pill	☐	☐	_____
ldecon 6) Decongestant (Sudafed, Contact, etc)	☐	☐	_____
labothmd 7) Other (Please Specify):_____	☐	☐	_____

lomed

4. Have you felt ill at all today or have you been ill in the last 2 weeks? _____ (0) No _____ (1)Yes fltill

If yes, what illness:

_____

5. How long ago were you last ill? (pick one)
willlast

1) 2 weeks ago or more
2) 7 to 13 days ago
3) 2 to 6 days ago
4) 1 day ago