HeMacinto
Sound Sleep Center
343 East Main Street Suite 106 San Jacinto, CA 92583
Tel: (951) 654-5592 Fax: (951) 654-0839
info@hemacintosleep.com

Pre-Sleep Questionnaire

Patient Name: _____ DOB: _____

Do you feel today has been an unusual day? ☐ Yes ☐ No
If yes, please explain_____

How much sleep did you have last night? _____Hours

Did you take a nap today? ☐ Yes ☐ No
If yes, how long was your nap _____Hours?

Approximately what time was your last full meal? _____

Did you drink any caffeine or alcohol today? ☐ Yes ☐ No
If yes, list type, amount, and time consumed _____

How are you feeling now?
☐ Alert and wide awake ☐ Relaxed and awake ☐ A little foggy, not great ☐ Sleepy, ready for bed

List any medications you have taken today? (Include OTC or prescription)

Medication Name	Amount/Dose	Approximate Time Taken

Any physical complaints? _____
_____