

SLEEP COHORT STUDY INTAKE FORM-2ND VISIT

VOLUNTEER'S NAME _____ ID# _____

ADDRESS _____

BIRTH DATE _____ SS# _____

ETHNIC GROUP _____ MR# _____

EMPLOYER _____ LAST SLEEP STUDY _____

PHONE (HOME) _____ (WORK) _____

EMERGENCY CONTACT _____

RELATIONSHIP _____ PHONE _____

Are you presently under the care of a physician for any serious medical condition? YES NO

(Diagnosis) _____

Usual Bedtime _____ Usual risetime _____

Do you have any special preparations before bedtime? YES NO

What time will you leave the hospital for work? _____

Early risetime (6:30 or before) _____ Late sleeper (after 6:30) _____

Breakfast option: Tray _____ Voucher _____

Do you have any dietary restrictions or preferences? YES NO

Dinner voucher needed? YES NO

APPOINTMENT DATE: _____ MSLT DATE: _____

ARRIVAL TIME: _____ 24 HOUR BP: _____ YES _____ NO

METHOD OF RESPONSE _____

DATE OF RESPONSE _____