PIMA LUNG & SLEEP, PC
SLEEP CENTER
AMITAB PURI, MD, FCCP, DABSM, FCCM
Pulmonary Medicine, Critical Care Medicine & Sleep Disorders Medicine

AM QUESTIONNAIRE

NAME:_____ GW ID: _____ RM# _____

TYPE OF STUDY _____TECHNICIAN _____DATE_____

1. What time did you feel that you awoke today? _____
2. How do you feel you slept last night? _____

   ❍ Better than usual ❍ Worse than usual ❍ Typical night rest
3. Was anything in particular disruptive to your sleep? ❍ Yes ❍ No

   If so, what? _____

On a scale from 1 (unlikely) to 10 (extremely likely), how likely would you be to recommend our services to a friend or colleage? _____

PATIENT SIGNATURE _____ DATE_____

AASM Accredited Sleep Centers & Member

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