Name:			
DOB:			
Date of Diary:		to	
	MM/DD/YY		MM/DD/YY

Sleep Diary

Use this sleep diary to record the quality and quantity of your sleep; medicines, alcohol, and caffeinated drinks; and how sleepy you feel during the day.
Make a copy of this diary if needed after finished it and send to us via patients portal.

Fill out before going to bed							Fill out in the morning						
Date (MM-DD-YY)	**How sleepy did I feel during the day today?** **1. Very sleepy** **2. Somewh at tired** **3. Fairly alert** **4. Alert**	**Number of caffeinated drinks (coffee, tea, soda) and time when I had them today**	**Number of alcoholic drinks (beer, wine, liquor) and time when I had them today**	**Any recreational drugs today? (Y/N. If Yes, name, time and quantity taken)**	**Naptimes and lengths today**	**Exercise times and lengths today**	**Bedtime**	**How long I took to fall asleep last night**	**Wakeup time**	**Hours spent in bed last night**	**Number of awakenings / Total time awake last night**	**Medicines taken last night**	**How alert did I feel when I got up this morning?** **1. Alert** **2. Alert but a little tired** **3. Sleepy**
Example 11-03-24	1	1 coffee, 9 am	2 beer, 9 pm	No	2:30 pm, 40 mins	None	11:30 pm	15 min	5:30 am	**6**	1/5 mins	None	2