

St. Joseph Mercy Oakland Sleep Disorders Center
Sleep Diary

Patient Name: _____ D.O.B.: _____

Begin filling this out each morning and finish at the end of each day.

Day of the Week:						
Date:						
Work Day/Day Off/Vacation?						
I went to bed last night at ____.						
Check all those that apply:	<input type="checkbox"/> I watched TV in bed. <input type="checkbox"/> I used the computer prior to bed. <input type="checkbox"/> I read in bed. <input type="checkbox"/> I took a sleep aid.	<input type="checkbox"/> I watched TV in bed. <input type="checkbox"/> I used the computer prior to bed. <input type="checkbox"/> I read in bed. <input type="checkbox"/> I took a sleep aid.	<input type="checkbox"/> I watched TV in bed. <input type="checkbox"/> I used the computer prior to bed. <input type="checkbox"/> I read in bed. <input type="checkbox"/> I took a sleep aid.			
Number of <i>caffeinated</i> beverages I drank yesterday:						
Number of <i>alcoholic</i> beverages I drank yesterday:						
It took me this long to fall asleep after turning the lights out:						
I woke up this many times after falling asleep:						
I woke up for these reasons (check all that apply):	<input type="checkbox"/> Bathroom <input type="checkbox"/> Heartburn <input type="checkbox"/> Hunger <input type="checkbox"/> Nasal Congestion <input type="checkbox"/> Pain <input type="checkbox"/> Pet	<input type="checkbox"/> Phone <input type="checkbox"/> Sleep Partner <input type="checkbox"/> Thirst <input type="checkbox"/> Unknown <input type="checkbox"/> Worry <input type="checkbox"/> Other:	<input type="checkbox"/> Bathroom <input type="checkbox"/> Heartburn <input type="checkbox"/> Hunger <input type="checkbox"/> Nasal Congestion <input type="checkbox"/> Pain <input type="checkbox"/> Pet	<input type="checkbox"/> Phone <input type="checkbox"/> Sleep Partner <input type="checkbox"/> Thirst <input type="checkbox"/> Unknown <input type="checkbox"/> Worry <input type="checkbox"/> Other:	<input type="checkbox"/> Bathroom <input type="checkbox"/> Heartburn <input type="checkbox"/> Hunger <input type="checkbox"/> Nasal Congestion <input type="checkbox"/> Pain <input type="checkbox"/> Pet	<input type="checkbox"/> Phone <input type="checkbox"/> Sleep Partner <input type="checkbox"/> Thirst <input type="checkbox"/> Unknown <input type="checkbox"/> Worry <input type="checkbox"/> Other:
I awoke for the day at:						
I got out of bed at:						
I used the snooze alarm ____ times.						
When I awoke I felt refreshed.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No			
I was sleepy today.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Today, I napped from ____ to ____ (Time & Duration)						
My nap was refreshing.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No			
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