Regions Hospital
SLEEP HEALTH CENTER

Name:_____

Start Date:_____

Please use a pen or pencil to keep a sleep diary for the next two weeks. On the back of this form, please fill out the comments section for each day. You should bring this completed diary with you when you come for your Sleep Study or next appointment.

	Noon			PM					Midnight					AM						Noon				
Date	12	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11
Example		----					*A*	*C*	*M*	----									----	*C*			*C*	

This person felt drowsy from 1-2:00pm; had one drink of alcohol at 6:00pm, and a caffeinated drink at 7:00pm. She took a sleep medication at 8:00pm, went to bed at 9:00pm, and laid awake in bed feeling drowsy from 5-6:00am. She had one caffeinated beverage at 7:00am and again at 10:00am.

In/Out of Bed	Wake	Drowsy	Sleep	Caffeine	Sleep Medication	Alcohol
I		----		C	M	A

SLEEP LOGS

08/2015

Additional Comments:

Please notate here if you took any sleep medications, consumed any alcohol or caffeinated beverages and the time that you did so. Feel free to include any other information you feel is important.

Day/Date:		Comment:
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		
11		
12		
13		
14		