Sleep Medicine Associates Sleep / Wake Diary

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
NAME: _____	DATE:	DATE:	DATE:	DATE:	DATE:	DATE:	DATE:
Answer the following in the morning							
What time did you get into bed last night?	:	:	:	:	:	:	:
What time did you turn everything off and try to fall asleep?							
How long did it take you to fall asleep after that?	:	:	:	:	:	:	:
What did you do between getting into bed and falling asleep?							
Did you wake up during the night? How often? How long were you awake total?							
What time was your final awakening this morning?	:	:	:	:	:	:	:
What time did you get out of bed?	:	:	:	:	:	:	:
Did anything unusual happen yesterday that might have affected your sleep? (Illness, disturbances, emotional stress, etc)							
What is the total amount of time you slept last night in hours and minutes? (Best estimate)							
Did you take any medication that might have affected your sleep? What? When?							
Answer the following in the evening							
Did you nap today? How many times? When? How long?							
Did you consume any medicine that you do not take on a daily basis? What? How much? When?							
Did you have any caffeinated or alcoholic beverages today? What? How much? When?							
Please rate your average sleepiness today on a scale of 1-10. 1=wide awake, 10=very sleepy.							

List any medications taken regularly—both prescription and over-the-counter, how much, and how often you are taking them:

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