Sleep Diary

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Patient_____ Beginning date _____

Don't watch the clock to record times. Use your best guess.

Date	Time I went to bed	Time I fell asleep	Medicine(s) I took	Number of times I woke up	Time it took to go back to sleep	Time I woke up	Total hours of sleep	Quality of sleep	Comments (exercise, naps, what I ate/drank, anything else that might affect my sleep).

Keep your diary for two weeks, then take it to your next doctor visit.

* (1=poor, 2=fair, 3=good)
** Medications I am currently taking: (please list by number, then place number in the box for the corresponding date._____
_____
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