

## National Sleep Foundation Sleep Diary

<b>Fill out days 1-4 below and days 5-7 on next page</b>	Complete in Morning							Complete at End of Day				
	I went to bed last night at:	I got out of bed this morning at:	Last night, I fell asleep in:	I woke up during the night:  (Record number of times)	When I woke up for the day, I felt:  (Check one)	Last night I slept a total of:  (Record number of hours)	My sleep was disturbed by:  (List any mental, emotional, physical or environmental factors that affected your sleep; e.g. stress, snoring, physical discomfort, temperature)	I consumed caffeinated drinks in the:  (e.g. coffee, tea, cola)	I exercised at least 20 minutes in the:	Approximately 2-3 hours before going to bed, I consumed:	Medication(s) I took during the day:  [List name of medication/ drug(s)]	About 1 hour before going to sleep, I did the following activity:  (List activity; e.g. watch TV, work, read)
<b>DAY 1</b> Day _____ Date _____	____PM/AM	____PM/AM	____Minutes	____Times	<input type="checkbox"/> Refreshed <input type="checkbox"/> Somewhat refreshed <input type="checkbox"/> Fatigued	____Hours	_____ _____ _____ _____	<input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Within several hours before going to bed <input type="checkbox"/> Not applicable	<input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Within several hours before going to bed <input type="checkbox"/> Not applicable	<input type="checkbox"/> Alcohol <input type="checkbox"/> A heavy meal <input type="checkbox"/> Not applicable	_____ _____ _____ _____	_____ _____ _____ _____
<b>DAY 2</b> Day _____ Date _____	____PM/AM	____PM/AM	____Minutes	____Times	<input type="checkbox"/> Refreshed <input type="checkbox"/> Somewhat refreshed <input type="checkbox"/> Fatigued	____Hours	_____ _____ _____ _____	<input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Within several hours before going to bed <input type="checkbox"/> Not applicable	<input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Within several hours before going to bed <input type="checkbox"/> Not applicable	<input type="checkbox"/> Alcohol <input type="checkbox"/> A heavy meal <input type="checkbox"/> Not applicable	_____ _____ _____ _____	_____ _____ _____ _____
<b>DAY 3</b> Day _____ Date _____	____PM/AM	____PM/AM	____Minutes	____Times	<input type="checkbox"/> Refreshed <input type="checkbox"/> Somewhat refreshed <input type="checkbox"/> Fatigued	____Hours	_____ _____ _____ _____	<input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Within several hours before going to bed <input type="checkbox"/> Not applicable	<input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Within several hours before going to bed <input type="checkbox"/> Not applicable	<input type="checkbox"/> Alcohol <input type="checkbox"/> A heavy meal <input type="checkbox"/> Not applicable	_____ _____ _____ _____	_____ _____ _____ _____
<b>DAY 4</b> Day _____ Date _____	____PM/AM	____PM/AM	____Minutes	____Times	<input type="checkbox"/> Refreshed <input type="checkbox"/> Somewhat refreshed <input type="checkbox"/> Fatigued	____Hours	_____ _____ _____ _____	<input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Within several hours before going to bed <input type="checkbox"/> Not applicable	<input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Within several hours before going to bed <input type="checkbox"/> Not applicable	<input type="checkbox"/> Alcohol <input type="checkbox"/> A heavy meal <input type="checkbox"/> Not applicable	_____ _____ _____ _____	_____ _____ _____ _____

## National Sleep Foundation Sleep Diary

Fill out days 5-7 below	Complete in Morning							Complete at End of Day				
	I went to bed last night at:	I got out of bed this morning at:	Last night, I fell asleep in:	I woke up during the night:  (Record number of times)	When I woke up for the day, I felt:  (Check one)	Last night I slept a total of:  (Record number of hours)	My sleep was disturbed by:  (List any mental, emotional, physical or environmental factors that affected your sleep; e.g. stress, snoring, physical discomfort, temperature)	I consumed caffeinated drinks in the:  (e.g. coffee, tea, cola)	I exercised at least 20 minutes in the:	Approximately 2-3 hours before going to bed, I consumed:	Medication(s) I took during the day:  [List name of medication/ drug(s)]	About 1 hour before going to sleep, I did the following activity:  (List activity; e.g. watch TV, work, read)
<b>DAY 5</b> Day _____ Date _____	____PM/AM	____PM/AM	____Minutes	____Times	<input type="checkbox"/> Refreshed <input type="checkbox"/> Somewhat refreshed <input type="checkbox"/> Fatigued	____Hours	_____ _____ _____ _____	<input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Within several hours before going to bed <input type="checkbox"/> Not applicable	<input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Within several hours before going to bed <input type="checkbox"/> Not applicable	<input type="checkbox"/> Alcohol <input type="checkbox"/> A heavy meal <input type="checkbox"/> Not applicable	_____ _____ _____ _____	_____ _____ _____ _____
<b>DAY 6</b> Day _____ Date _____	____PM/AM	____PM/AM	____Minutes	____Times	<input type="checkbox"/> Refreshed <input type="checkbox"/> Somewhat refreshed <input type="checkbox"/> Fatigued	____Hours	_____ _____ _____ _____	<input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Within several hours before going to bed <input type="checkbox"/> Not applicable	<input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Within several hours before going to bed <input type="checkbox"/> Not applicable	<input type="checkbox"/> Alcohol <input type="checkbox"/> A heavy meal <input type="checkbox"/> Not applicable	_____ _____ _____ _____	_____ _____ _____ _____
<b>DAY 7</b> Day _____ Date _____	____PM/AM	____PM/AM	____Minutes	____Times	<input type="checkbox"/> Refreshed <input type="checkbox"/> Somewhat refreshed <input type="checkbox"/> Fatigued	____Hours	_____ _____ _____ _____	<input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Within several hours before going to bed <input type="checkbox"/> Not applicable	<input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Within several hours before going to bed <input type="checkbox"/> Not applicable	<input type="checkbox"/> Alcohol <input type="checkbox"/> A heavy meal <input type="checkbox"/> Not applicable	_____ _____ _____ _____	_____ _____ _____ _____

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