

# Sleep Log

Today's Date: \_\_\_\_\_ Date of Sleep Study: \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Current Weight: \_\_\_\_\_ What Was/Is Your Maximum Weight: \_\_\_\_\_ Height: \_\_\_\_\_

Please complete this form to the best of your ability. Work backwards from day 7, which was the day before your scheduled test date.

This information is very important to your sleep testing!

Please Complete!	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
List how many <b>Naps</b> you have had today and the length in minutes of all the Naps combined?							
List any prescription medications that you <b>DIDN'T</b> take as you usually would today?							
List the amount and time of any <b>alcohol, caffeine, or tobacco</b> that you have had in the last 10 hours before bed.							
What was your bedtime?							
What was your final wake time?							
How many times did you awaken during the night? List how long you were up and reason for the awakenings if known.							
After you subtract your awakenings, how many hours of <b>sleep</b> did you get?							
How did you feel when you first woke up for the day? ( <b>In 1 or 2 words</b> )							