

National Sleep Foundation Sleep Diary

Fill out days 1-4 below and days 5-7 on page 2	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: <small>(Record number of times)</small>	When I woke up for the day, I felt: <small>(Check one)</small>	Last night I slept a total of: <small>(Record number of hours)</small>	My sleep was disturbed by: <small>(List any mental, emotional, physical or environmental factors that affected your sleep; e.g. stress, snoring, physical discomfort, temperature)</small>	I consumed caffeinated drinks in the: <small>(e.g. coffee, tea, cola)</small>	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: <small>[List name of medication/drug(s)]</small>	About 1 hour before going to sleep, I did the following activity: <small>(List activity; e.g. watch TV, work, read)</small>
DAY 1 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	_____ _____ _____ _____	_____ _____ _____ _____
DAY 2 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	_____ _____ _____ _____	_____ _____ _____ _____
DAY 3 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	_____ _____ _____ _____	_____ _____ _____ _____
DAY 4 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: <small>(Record number of times)</small>	When I woke up for the day, I felt: <small>(Check one)</small>	Last night I slept a total of: <small>(Record number of hours)</small>	My sleep was disturbed by: <small>(List any mental, emotional, physical or environmental factors that affected your sleep; e.g. stress, snoring, physical discomfort, temperature)</small>	I consumed caffeinated drinks in the: <small>(e.g. coffee, tea, cola)</small>	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: <small>[List name of medication/drug(s)]</small>	About 1 hour before going to sleep, I did the following activity: <small>(List activity; e.g. watch TV, work, read)</small>
DAY 5 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	_____ _____ _____ _____	_____ _____ _____ _____
DAY 6 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	_____ _____ _____ _____	_____ _____ _____ _____
DAY 7 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	_____ _____ _____ _____	_____ _____ _____ _____