



SLEEP DISORDER CENTER
Accredited by the American Academy of Sleep Medicine

Please fill out attached sleep diary, per the instructions below, for 1 week. Please bring completed diary with you to your appointment.

NAME: _____

DATE: _____

DAY OF THE WEEK: _____
(1st day test is started)

INSTRUCTIONS:

Please leave your diary near your bedside. It is important that you fill out the chart each morning.

MARK YOUR DIARY IN THE FOLLOWING WAY:

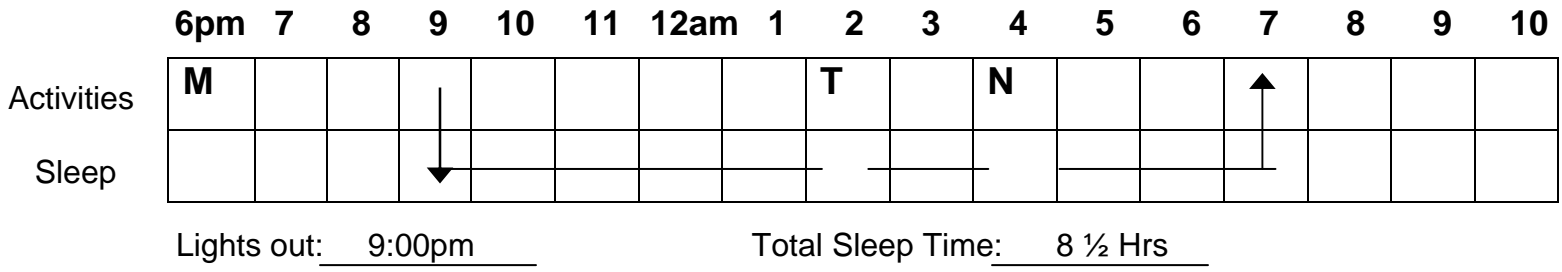
BOX 1) ACTIVITIES:

- A** Each alcoholic drink
- C** Each caffeinated drink (incl: coffee, tea, chocolate, soda, etc.)
- P** Every time you take a sleeping pill or tranquilizer
- T** Use of toilet during sleep time
- M** Meals
- S** Snacks
- N** Noises that disturb your sleep
- W** Time of wake up alarm (if any)

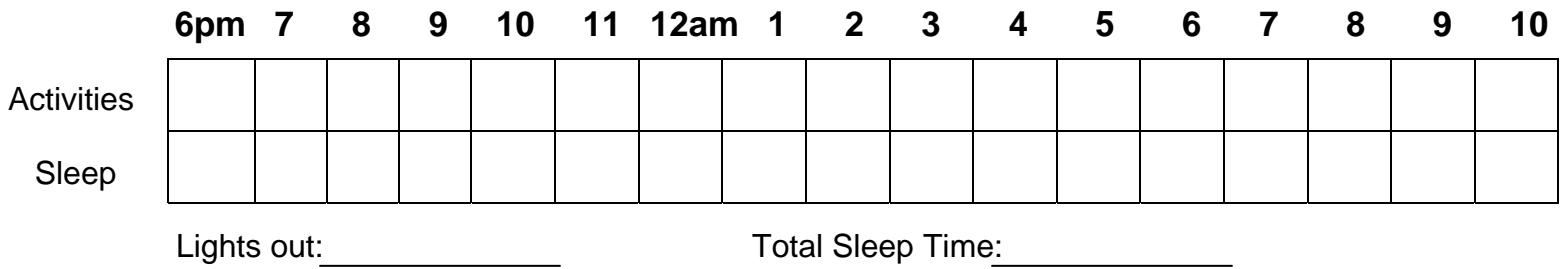
BOX 2) SLEEP INFO:

- ↑ When you get in to bed
 - ↓ When you get out of bed
 - Please draw a vertical line to show the *begin* and *end* of sleep time
- Please describe on the back any events other than those listed that influenced your sleep

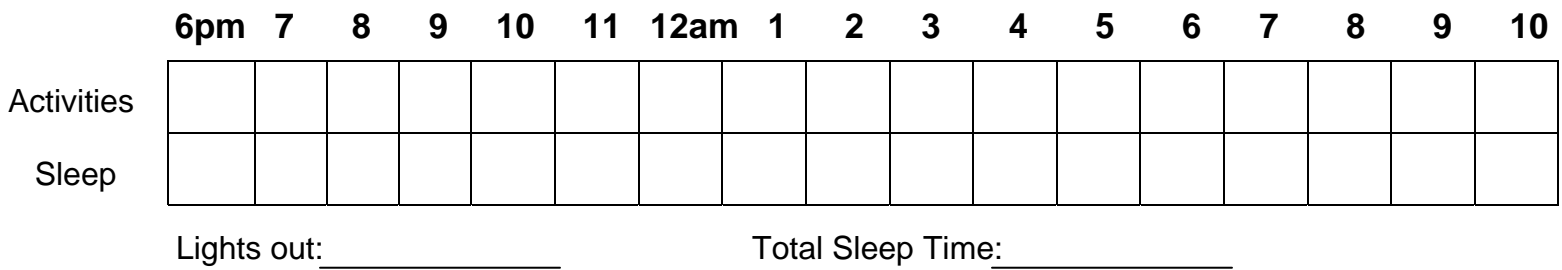
EXAMPLE



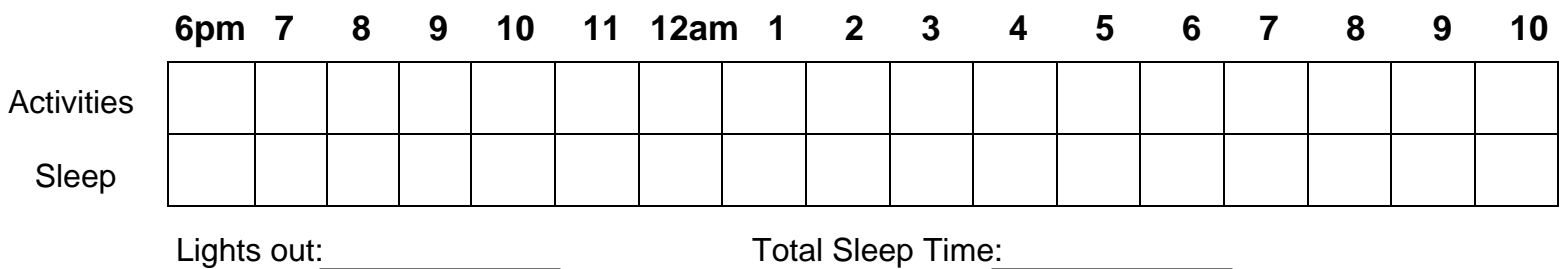
Night 1)



Night 2)



Night 3)



Night 4)

6pm 7 8 9 10 11 12am 1 2 3 4 5 6 7 8 9 10

Activities																	
Sleep																	

Lights out: _____

Total Sleep Time: _____

Night 5)

6pm 7 8 9 10 11 12am 1 2 3 4 5 6 7 8 9 10

Activities																	
Sleep																	

Lights out: _____

Total Sleep Time: _____

Night 6)

6pm 7 8 9 10 11 12am 1 2 3 4 5 6 7 8 9 10

Activities																	
Sleep																	

Lights out: _____

Total Sleep Time: _____

Night 7)

6pm 7 8 9 10 11 12am 1 2 3 4 5 6 7 8 9 10

Activities																	
Sleep																	

Lights out: _____

Total Sleep Time: _____