THE SLEEP DISORDERS CENTERS
of PULMONARY ASSOCIATES

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PATIENT INSTRUCTIONS: SLEEP DIARY

To better understand your sleep and to assist in your diagnosis, we need to collect very important information on your sleep patterns. Please read the instructions carefully and complete your **SLEEP DIARY** for a two week period. The **SLEEP DIARY** should be kept on your nightstand so you can complete it every morning as soon as you wake up. It is better to answer questions with your "best guess" than to leave any blank spaces.

Question 1. The time that you actually turn off the lights and decide to try to sleep.

Question 2. Your estimate of the number of minutes it took to fall asleep after you turned out the lights.

Question 3. The final awakening for the morning: For example, if you woke up at 6:00 a.m., but then fell back asleep until 6:25 a.m., your answer would be 6:25.

Question 4. The time you got out of bed to actually start your day.

Question 5. The number of hours you actually slept - Not the number of hours you were in bed.

Question 6. The number of times you remember waking up at night.

Question 7. The total time all of your awakenings: For example, if you listed 3 awakenings and the first was 5 minutes, the second was 20 minutes, and the third was 15 minutes, then your answer to this question is 40 minutes.

Question 8. The name of the medication and the dose or type of alcohol and the amount . Include non-prescription medications, such as Benadryl, etc.

Question 9. The time of each nap, including any unintentional naps or "dozing off" for a few minutes.

Question 10. Your evaluation of how tired you were when you woke up:
1= Exhausted; 2=Tired; 3=Average; 4=Rather Refreshed; 5=Very Refreshed.

Question 11. Your evaluation of you overall quality of your sleep:
1=Very Disrupted; 2=Restless; 3=Average; Quality, 4=Sound; 5=Very Sound.

If there are any unusual occurrences, such as an illness, emergency, or telephone call, that disrupts your sleep, please make note of this at the bottom of your SLEEP DIARY. Thank you.

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Patient's Name: _____

Date of Birth: _____

Sex: ☐ M ☐ F Chart # _____

Home Medical Supply Co. _____

SLEEP STUDY DIARY

WEEK STARTING: _____	EXAMPLE: WEDNESDAY	TODAY IS:	TODAY IS:	TODAY IS:	TODAY IS:	TODAY IS:	TODAY IS:	TODAY IS:
1. Last night, I turned off the lights at _____ am/pm	11:45 pm							
2. After turning out the lights, I fell asleep in _____ minutes.	25 min							
3. This morning I woke up at _____ am/pm. Note the time of your last awakening.	6:15 am							
4. This morning I got out of bed at _____ am/pm.	6:30 am							
5. I felt I slept a total of _____ hours last night.	6 hours							
6. My sleep was interrupted _____ times. Specify the number of night-time awakenings.	3							
7. I was awake for a total of _____ minutes when I add all awakenings.	40 min.							
8. Yesterday I took _____ mg of medication and/or _____ ounces of alcohol as a sleep aid.	Ambien-5mg							
9. Yesterday, I napped from _____ am/pm to _____ am/pm. Note the time of all naps taken.	1:00-1:30 5:00-5:15 8:00-8:45							
10. When I got up this morning, I felt: (1=Exhausted, 5 = Refreshed)	3							
11. Overall, my sleep last night was: (1=Very Restless, 5=Very Sound)	3							

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