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:** *(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)*
DAY 1 DAY_____ DATE_____	_____PM/AM	_____PM/AM	___Minutes	_____Times	☐ Refreshed ☐ Somewhat refreshed ☐ Fatigued	_____Hours	_____ _____ _____ _____ _____	☐ Morning ☐ Afternoon ☐ Within several hours before going to bed ☐ Not applicable	☐ Morning ☐ Afternoon ☐ Within several hours before going to bed ☐ Not applicable	☐ Alcohol ☐ A heavy meal ☐ Not applicable	_____ _____ _____ _____ _____	_____ _____ _____ _____ _____
DAY 2 DAY_____ DATE_____	_____PM/AM	_____PM/AM	___Minutes	_____Times	☐ Refreshed ☐ Somewhat refreshed ☐ Fatigued	_____Hours	_____ _____ _____ _____ _____	☐ Morning ☐ Afternoon ☐ Within several hours before going to bed ☐ Not applicable	☐ Morning ☐ Afternoon ☐ Within several hours before going to bed ☐ Not applicable	☐ Alcohol ☐ A heavy meal ☐ Not applicable	_____ _____ _____ _____ _____	_____ _____ _____ _____ _____
DAY 3 DAY_____ DATE_____	_____PM/AM	_____PM/AM	___Minutes	_____Times	☐ Refreshed ☐ Somewhat refreshed ☐ Fatigued	_____Hours	_____ _____ _____ _____ _____	☐ Morning ☐ Afternoon ☐ Within several hours before going to bed ☐ Not applicable	☐ Morning ☐ Afternoon ☐ Within several hours before going to bed ☐ Not applicable	☐ Alcohol ☐ A heavy meal ☐ Not applicable	_____ _____ _____ _____ _____	_____ _____ _____ _____ _____
DAY 4 DAY_____ DATE_____	_____PM/AM	_____PM/AM	___Minutes	_____Times	☐ Refreshed ☐ Somewhat refreshed ☐ Fatigued	_____Hours	_____ _____ _____ _____ _____	☐ Morning ☐ Afternoon ☐ Within several hours before going to bed ☐ Not applicable	☐ Morning ☐ Afternoon ☐ Within several hours before going to bed ☐ Not applicable	☐ Alcohol ☐ A heavy meal ☐ 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)*
DAY 5 DAY_____ DATE_____	_____PM/AM	_____PM/AM	____Minutes	_____Times	☐ Refreshed ☐ Somewhat refreshed ☐ Fatigued	_____Hours	_____	☐ Morning ☐ Afternoon ☐ Within several hours before going to bed ☐ Not applicable	☐ Morning ☐ Afternoon ☐ Within several hours before going to bed ☐ Not applicable	☐ Alcohol ☐ A heavy meal ☐ Not applicable	_____	_____
DAY 6 DAY_____ DATE_____	_____PM/AM	_____PM/AM	____Minutes	_____Times	☐ Refreshed ☐ Somewhat refreshed ☐ Fatigued	_____Hours	_____	☐ Morning ☐ Afternoon ☐ Within several hours before going to bed ☐ Not applicable	☐ Morning ☐ Afternoon ☐ Within several hours before going to bed ☐ Not applicable	☐ Alcohol ☐ A heavy meal ☐ Not applicable	_____	_____
DAY 7 DAY_____ DATE_____	_____PM/AM	_____PM/AM	____Minutes	_____Times	☐ Refreshed ☐ Somewhat refreshed ☐ Fatigued	_____Hours	_____	☐ Morning ☐ Afternoon ☐ Within several hours before going to bed ☐ Not applicable	☐ Morning ☐ Afternoon ☐ Within several hours before going to bed ☐ Not applicable	☐ Alcohol ☐ A heavy meal ☐ Not applicable	_____	_____