Pulmonary Medicine, Critical Care Medicine & Sleep Disorders Medicine

PIMA LUNG & SLEEP, PC

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SLEEP LOG FORM

Name: _____ Week of: _____

Sleep logs can be helpful for diagnoses of sleep disorders. They are the most efficient way for you and your doctor to evaluate your sleep difficulties. Any patient of a sleep disorder clinic is required to keep a sleep log. More than likely, your doctor will ask you to complete a sleep log for a period of several weeks; already completing this log may expedite your diagnosis and treatment. Most sleep specialists recommend maintaining a sleep log for 2-4 consecutive weeks. Bring this sleep log to your doctor or sleep specialist at the time of your appointment. Please fill out this sleep log for the previous day and night no more than 3 hours after waking up. Estimate approximate times for each of the questions. Detailed accuracy is not essential.

DAY	SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
Did you take a nap For how long? (_____mins.) At what time?	YES ☐ NO ☐ _____ mins. _____	YES ☐ NO ☐ _____ mins. _____	YES ☐ NO ☐ _____ mins. _____	YES ☐ NO ☐ _____ mins. _____	YES ☐ NO ☐ _____ mins. _____	YES ☐ NO ☐ _____ mins. _____	YES ☐ NO ☐ _____ mins. _____
Did you have any caffeine*after 6 p.m.?	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐
Did you have any alcohol after 6 p.m.?	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐
Did you use nicotine after 6 p.m.?	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐
Did you exercise?	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐
Did you eat a heavy meal or snack after 6 p.m.?	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐
Did you take any sleep medication? What medicine? Amount? At what time?	YES ☐ NO ☐ _____ _____ _____	YES ☐ NO ☐ _____ _____ _____	YES ☐ NO ☐ _____ _____ _____	YES ☐ NO ☐ _____ _____ _____	YES ☐ NO ☐ _____ _____ _____	YES ☐ NO ☐ _____ _____ _____	YES ☐ NO ☐ _____ _____ _____
Were you sleepy during the day?	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐
NIGHT							
At what time did you turn off your lights?							
At what time did you wake up?							
How many total hours did you sleep?							
How many times did you wake up or get up?							
Rate the quality of your sleep. 1 = poor 5 = excellent							
Do you feel that you got enough sleep?	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐

*Caffeine = coffee, tea, caffeinated sada, chocolate, certain medications