ST. JOSEPH MERCY OAKLAND
SAINT JOSEPH MERCY HEALTH SYSTEM

St. Joseph Mercy Oakland Sleep Disorders Center

Sleep Diary

Patient Name: ______________________________ D.O.B.: ____________

Begin filling this out each morning and finish at the end of each day.

Day of the Week:			
Date:			
Work Day/Day Off/Vacation?			
I went to bed last night at ____.			
Check all those that apply:	❑ I watched TV in bed. ❑ I used the computer prior to bed. ❑ I read in bed. ❑ I took a sleep aid.	❑ I watched TV in bed. ❑ I used the computer prior to bed. ❑ I read in bed. ❑ I took a sleep aid.	❑ I watched TV in bed. ❑ I used the computer prior to bed. ❑ I read in bed. ❑ I took a sleep aid.
Number of *caffeinated beverages* I drank yesterday:			
Number of *alcoholic beverages* I drank yesterday:			
It took me this long to fall asleep after turning the lights out:			
I woke up this many times after falling asleep:			
I woke up for these reasons (check all that apply):	❑ Bathroom ❑ Heartburn ❑ Hunger ❑ Nasal Congestion ❑ Pain ❑ Pet ❑ Phone ❑ Sleep Partner ❑ Thirst ❑ Unknown ❑ Worry ❑ Other:	❑ Bathroom ❑ Heartburn ❑ Hunger ❑ Nasal Congestion ❑ Pain ❑ Pet ❑ Phone ❑ Sleep Partner ❑ Thirst ❑ Unknown ❑ Worry ❑ Other:	❑ Bathroom ❑ Heartburn ❑ Hunger ❑ Nasal Congestion ❑ Pain ❑ Pet ❑ Phone ❑ Sleep Partner ❑ Thirst ❑ Unknown ❑ Worry ❑ Other:
I awoke for the day at:			
I got out of bed at:			
I used the snooze alarm ____ times.			
When I awoke I felt refreshed.	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
I was sleepy today.	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
Today, I napped from ____to ____. (Time & Duration)			
My nap was refreshing.	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
Other factors that could have affected my sleep last night & my state of alertness today:			

Physician Review: ______________________________ Date: ____________

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