

Sleep Center Sleep Log

Patient Name:	Date of Birth:

Fill out for **two weeks** up to and including the **day of testing/appointment.**

Date	7 pm	8	9	10	11 ->	12 am	1	² →	3 →	4	5 →	6 am	7 →	8	9	10 ->	11 ->	12 pm	1	² →	3 →	4	5 →	6 pm	Comments
Example			9:30									† 6:30									↓ 3		† 5:00		Caffeine 12pm Exercise 5-6
Week 1																									
Week	2	<u>I</u>					<u>I</u>								I			<u>I</u>	<u>I</u>						ı

Instructions: • ↓ time in bed • Shade all times asleep • ↑ time out of bed • Add comments • Please use pencil or pen only.