INLAND PAIN MEDICINE: SLEEP LOG

Sleep diaries 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.

Name: ____

Week of: ______________________________________

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Date:					___________		
DAY							
1) Did you take a nap? a) For how long? b) At what time?	Yes☐ No☐ ______mins. ___________	Yes☐ No☐ ______mins. ___________	Yes☐ No☐ ______mins. ___________	Yes☐ No☐ ______mins. ___________	Yes☐ No☐ ______mins. ___________	Yes☐ No☐ ______mins. ___________	Yes☐ No☐ ______mins. ___________
2) Did you have any caffeine* after 6 p.m.?	Yes☐ No☐	Yes☐ No☐	Yes☐ No☐	Yes☐ No☐	Yes☐ No☐	Yes☐ No☐	Yes☐ No☐
3) Did you have any alcohol after 6 p.m.?	Yes☐ No☐	Yes☐ No☐	Yes☐ No☐	Yes☐ No☐	Yes☐ No☐	Yes☐ No☐	Yes☐ No☐
4) Did you use nicotine after 6 p.m.?	Yes☐ No☐	Yes☐ No☐	Yes☐ No☐	Yes☐ No☐	Yes☐ No☐	Yes☐ No☐	Yes☐ No☐
5) Did you exercise?	Yes☐ No☐	Yes☐ No☐	Yes☐ No☐	Yes☐ No☐	Yes☐ No☐	Yes☐ No☐	Yes☐ No☐
6) 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☐
7) Did you take any sleeping medication? a) What medication? b) Amount? c) At what time?	Yes☐ No☐ ___________ ___________ ___________	Yes☐ No☐ ___________ ___________ ___________	Yes☐ No☐ ___________ ___________ ___________	Yes☐ No☐ ___________ ___________ ___________	Yes☐ No☐ ___________ ___________ ___________	Yes☐ No☐ ___________ ___________ ___________	Yes☐ No☐ ___________ ___________ ___________
8) Were you sleepy during the day?	Yes☐ No☐	Yes☐ No☐	Yes☐ No☐	Yes☐ No☐	Yes☐ No☐	Yes☐ No☐	Yes☐ No☐
NIGHT							
1) At what time did you turn off your lights to go to sleep?							
2) At what time did you wake up?							
3) How many total hours did you sleep?							
4) How many times did you wake up or get up during the night?							
5) Rate the quality of your sleep: 1 = poor 5 = excellent							
6) Do you feel that you got an adequate amount of sleep?	Yes☐ No☐	Yes☐ No☐	Yes☐ No☐	Yes☐ No☐	Yes☐ No☐	Yes☐ No☐	Yes☐ No☐

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