

Sleep Journal

Fill out this sleep journal every morning for 1 to 2 weeks. It can help you see what gets in the way of a good night's sleep. It could also help your doctor know more about what affects your sleep.

| Day | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|--|---|---|---|---|---|---|---|
| What time did you go to bed last night? | | | | | | | |
| How long did it take to fall asleep? | | | | | | | |
| What time did you get up? | | | | | | | |
| Did you wake up during your sleep time? How many times? For how long? Did you get out of bed? | | | | | | | |
| How much total sleep did you get? | | | | | | | |
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| How tired do you feel, on a scale of 1 to 5? (Very tired = 5) | | | | | | | |
| Overall, how tired did you feel yesterday, on a scale of 1 to 5? (Very tired = 5) | | | | | | | |
| How unusual or stressful was your day yesterday, on a scale of 1 to 5? (Very unusual or stressful = 5) | | | | | | | |

| Day | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|--|---|---|---|---|---|---|---|
| What did you do during the 30 minutes before bed? | | | | | | | |
| Yesterday, did you: Take any naps? How long? When? | | | | | | | |
| Yesterday, did you: Drink alcohol? How much? | | | | | | | |
| Yesterday, did you: Have any caffeine? How much? When? | | | | | | | |
| Yesterday, did you: Do any physical activity? What? When? | | | | | | | |
| Yesterday, did you: Eat big or spicy meals? What? When? | | | | | | | |
| Yesterday, did you: Take any medicines, including over-the-counter or herbal ones? What? When? | | | | | | | |

