



Athens Sleep Center Sleep Diary

| COMPLETE IN MORNING | | | | | | | |
|------------------------------|---------------------------------|--------------------------------------|----------------------------------|---|--|--|---|
| (903) 675-1717 | I went to bed last night at: | I got out of bed this morning at: | Last night, I fell asleep in: | I woke up during the night: <i>(Record number of times)</i> | When I woke up for the day I felt: <i>(Circle one)</i> | Last night I slept a total of: <i>(Record number of hours)</i> | My sleep was disturbed by: <i>(List any mental, emotional, physical or environmental factors that affected your sleep; e.g. stress, snoring, physical discomfort, temperature)</i> |
| DAY 1 Day____ Date____ | _____ AM/PM | _____ AM/PM | _____ Minutes | _____ Times | Refreshed Somewhat refreshed Fatigued | _____ Hours | _____ _____ _____ |
| DAY 2 Day____ Date____ | _____ AM/PM | _____ AM/PM | _____ Minutes | _____ Times | Refreshed Somewhat refreshed Fatigued | _____ Hours | _____ _____ _____ |
| DAY 3 Day____ Date____ | _____ AM/PM | _____ AM/PM | _____ Minutes | _____ Times | Refreshed Somewhat refreshed Fatigued | _____ Hours | _____ _____ _____ |
| DAY 4 Day____ Date____ | _____ AM/PM | _____ AM/PM | _____ Minutes | _____ Times | Refreshed Somewhat refreshed Fatigued | _____ Hours | _____ _____ _____ |
| DAY 5 Day____ Date____ | _____ AM/PM | _____ AM/PM | _____ Minutes | _____ Times | Refreshed Somewhat refreshed Fatigued | _____ Hours | _____ _____ _____ |



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| COMPLETE AT END OF DAY | | | | | |
|------------------------------|--|--|--|--|--|
| (903) 675-1717 | I consumed caffeinated drinks in the: <i>(e.g. coffee, tea, cola) (circle all that apply)</i> | I exercised at least 20 minutes in the: | Approximately 2-3 hours before going to bed, I consumed: | Medication(s) I took during the day: <i>(List name of medication/drug(s))</i> | About 1 hour before going to sleep, I did the following activity: <i>(List activity; e.g. watch TV, work, read)</i> |
| DAY 1 Day____ Date____ | Morning Afternoon Within several hours before going to bed Not applicable | Morning Afternoon Within several hours before going to bed Not applicable | Alcohol A heavy meal Not applicable | _____ _____ _____ | _____ _____ _____ |
| DAY 2 Day____ Date____ | Morning Afternoon Within several hours before going to bed Not applicable | Morning Afternoon Within several hours before going to bed Not applicable | Alcohol A heavy meal Not applicable | _____ _____ _____ | _____ _____ _____ |
| DAY 3 Day____ Date____ | Morning Afternoon Within several hours before going to bed Not applicable | Morning Afternoon Within several hours before going to bed Not applicable | Alcohol A heavy meal Not applicable | _____ _____ _____ | _____ _____ _____ |
| DAY 4 Day____ Date____ | Morning Afternoon Within several hours before going to bed Not applicable | Morning Afternoon Within several hours before going to bed Not applicable | Alcohol A heavy meal Not applicable | _____ _____ _____ | _____ _____ _____ |
| DAY 5 Day____ Date____ | Morning Afternoon Within several hours before going to bed Not applicable | Morning Afternoon Within several hours before going to bed Not applicable | Alcohol A heavy meal Not applicable | _____ _____ _____ | _____ _____ _____ |