Sleep Log

Please fill this out for the previous day and night no more than 3 hours after waking.
The information can be an estimate when necessary.

SleepFoundation
A OneCare Media Company

NAME _____ WEEK OF _____

DAY	SUN	MON	TUES	WED	THURS	FRI	SAT
Did you nap?	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
For how long?	mins.	mins.	mins.	mins.	mins.	mins.	mins.
At what time?							
Did you have any caffeine* after 6pm?	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
Did you drink alcohol after 6pm?	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
Did you use nicotine after 6pm?	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
Did you exercise?	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
Did you eat a heavy meal or snack after 6pm?	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
Did you take any sleeping medication	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
What medication?							
Amount							
At what time?							
Were you sleepy during the day?	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
NIGHT							
What time did you turn off the lights to go to sleep?							
What time did you wake up?							
How many total hours did you sleep?							
How many times did you wake up in the night?							
Rate the quality of your sleep:	○○○○○	○○○○○	○○○○○	○○○○○	○○○○○	○○○○○	○○○○○
Do you feel you got enough sleep?							

* Caffeine = coffee, tea, caffeinated soda, chocolate, energy drinks, certain medications.