

Please complete this log on a daily basis for seven consecutive days prior to your scheduled procedure.

DAILY SLEEP LOG

NAME: _____	DAY 1 day _____ Date _____	DAY 2 day _____ Date _____	DAY 3 day _____ Date _____	DAY 4 day _____ Date _____	DAY 5 day _____ Date _____	DAY 6 day _____ Date _____	DAY 7 day _____ Date _____
1. What time did you go to bed last night?							
2. How long did it take you to fall asleep?							
3. How many times did you wake up during the night? a. Do you know why? b. How long were you awake?							
4. What time did you wake up this morning?							
5. What time did you get out of bed?							
6. How did you feel this morning?							
7. Did you nap today? a. When? b. How long?							
8. Are you now taking prescribed medication? a. What? b. How much? c. When?							
9. Have you had coffee, tea, or cola drink today? a. How much? b. When?							
10. Have you had any alcohol today?							
11. Did anything unusual or stressful happen today?							