SLEEP LOG

Name: _____ Date: _____

DOB: _____

In order to provide your physician with pertinent information needed to help diagnose your sleep disorder, please complete the sleep log for *at least 10 to 14 nights* to the best of your ability.

Date	Go to bed Time	How long to fall asleep after getting into bed?	How many times did you wake up?	Get out of bed time	List any sleep aid, TV, Drug, alcohol, other	Total Hours of Sleep	How was your sleep quality? (Scale: 0=poor, 5=good)

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