ANSWER these after you get up.	SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
I went to bed at:	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM
I fell asleep at:	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM
I woke up at:	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM
I slept: (record how many hours you slept)	**hours**	**hours**	**hours**	**hours**	**hours**	**hours**	**hours**
How often did you wake up during your sleep time?	**times**	**times**	**times**	**times**	**times**	**times**	**times**
My stress level was 1-10 (1 = low, 10= high)							
I exercised yesterday. List time you started, for how long and type (walking, etc).	AM PM minutes	AM PM minutes	AM PM minutes	AM PM minutes	AM PM minutes	AM PM minutes	AM PM minutes
I had caffeine and/or alcohol yesterday. List time (s) and number of drinks.							
If you use tobacco, list type (cigarettes, chew, etc.), amount and times.							
I took a nap yesterday.	AM PM minutes	AM PM minutes	AM PM minutes	AM PM minutes	AM PM minutes	AM PM minutes	AM PM minutes
List medications you took yesterday.							
List what you did 1 hour before going to sleep.							

Personal Best

SLEEP DIARY

Use this form to record your sleep habits and identify factors which may interfere with your sleep. Share your sleep diary with your doctor or health care provider.