PREMIER LUNG & SLEEP SPECIALISTS
PULMONICS PLUS

Sleep Diary:

Fill out side 1 in the morning when you get up and side 2 prior to going to bed at night.

	I Went to bed at what time	**Last night I fell asleep in:**	**I woke up at what time**	**Got out of bed at what time this morning**	**How long did you spend in bed?** *(from time of getting into bed till getting out)*	**I woke up during the night:** *(# of times & for how long)*	**When I woke up for the day I felt:**	**Last night I slept a total of:**	**Sleep was disturbed by:** *(Anything that disrupted your sleep, snoring, temperature, stress, pain, pets, partner)*	**Rate the Quality of sleep last night**
Day________ **Date_______**	__________ AM PM	_________ Minutes	__________ AM PM	__________ AM PM	________ Hours	____ Times ____ Min	❑ Refreshed ❑ Somewhat refreshed ❑ Fatigued	_______ Hours		❑ Poor ❑ Fair ❑ Good ❑ Excellent
Day________ **Date_______**	__________ AM PM	_________ Minutes	__________ AM PM	__________ AM PM	________ Hours	____ Times ____ Min	❑ Refreshed ❑ Somewhat refreshed ❑ Fatigued	_______ Hours		❑ Poor ❑ Fair ❑ Good ❑ Excellent
Day________ **Date_______**	__________ AM PM	_________ Minutes	__________ AM PM	__________ AM PM	________ Hours	____ Times ____ Min	❑ Refreshed ❑ Somewhat refreshed ❑ Fatigued	_______ Hours		❑ Poor ❑ Fair ❑ Good ❑ Excellent
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	I consumed caffeinated drinks or foods in the: (Coffee, tea, soda, energy drinks, chocolate etc.)	I exercised at least 20 minutes in the:	I napped today	2-3 hours prior to bed I consumed:	1 Hr before going to bed I did the following: (Read, Watch TV, work, games on phone,warm bath)	Medications taken today AM/PM
Day ________ Date ________	❑ Morning ____#Cups ❑ Afternoon ____# servings ❑ Within a few hours of bed _____# servings ❑ Did not consume	❑ Morning ❑ Afternoon ❑ Within 4 hrs of bed ❑ Did not exercise	❑No ❑ Yes How long__________ Refreshing ❑ Yes ❑ No	❑ Alcohol ❑ A heavy Meal ❑ Nicotene		
Day ________ Date ________	❑ Morning ____#Cups ❑ Afternoon ____# servings ❑ Within a few hours of bed _____# servings ❑ Did not consume	❑ Morning ❑ Afternoon ❑ Within 4 hrs of bed ❑ Did not exercise	❑No ❑ Yes How long__________ Refreshing ❑ Yes ❑ No	❑ Alcohol ❑ A heavy Meal ❑ Nicotene		
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