Imprint From Patient Data Card

Northfield Hospital + Clinics

DAILY SLEEP DIARY

To help us understand your sleep problems, we need a report of the times when you sleep, nap, and wake-up during sleep. In addition, we need to know if you consumed any caffeine, alcoholic beverages or medications. Keep this diary for 7 days. Answer each day's question by checking the appropriate boxes. If you are unsure of answers give your best estimate.

Please note the calendar date for Day 1: _____ / _____ / 2 0 _____ . Monday. Tuesday. Wednesday. Thursday. Friday. Saturday. Sunday

Day of Week	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
About what time did you go to bed?	❑ AM ❑ PM	❑ AM ❑ PM	❑ AM ❑ PM	❑ AM ❑ PM	❑ AM ❑ PM	❑ AM ❑ PM	❑ AM ❑ PM
How long did it take for you to fall asleep?	_____minutes	_____minutes	_____minutes	_____minutes	_____minutes	_____minutes	_____minutes
About how many times did you wake during the night?	_____times	_____times	_____times	_____times	_____times	_____times	_____times
About how many hours did you sleep?	_____hours	_____hours	_____hours	_____hours	_____hours	_____hours	_____hours
What time did you get out of bed?	❑ AM ❑ PM	❑ AM ❑ PM	❑ AM ❑ PM	❑ AM ❑ PM	❑ AM ❑ PM	❑ AM ❑ PM	❑ AM ❑ PM
How refreshed did you feel when you got up?	❑ Very refreshed ❑ Somewhat refreshed ❑ Fatigued	❑ Very refreshed ❑ Somewhat refreshed ❑ Fatigued	❑ Very refreshed ❑ Somewhat refreshed ❑ Fatigued	❑ Very refreshed ❑ Somewhat refreshed ❑ Fatigued	❑ Very refreshed ❑ Somewhat refreshed ❑ Fatigued	❑ Very refreshed ❑ Somewhat refreshed ❑ Fatigued	❑ Very refreshed ❑ Somewhat refreshed ❑ Fatigued
How difficult was it for you to stay awake during the day?	❑ Extremely difficult ❑ Somewhat difficult ❑ Not difficult at all	❑ Extremely difficult ❑ Somewhat difficult ❑ Not difficult at all	❑ Extremely difficult ❑ Somewhat difficult ❑ Not difficult at all	❑ Extremely difficult ❑ Somewhat difficult ❑ Not difficult at all	❑ Extremely difficult ❑ Somewhat difficult ❑ Not difficult at all	❑ Extremely difficult ❑ Somewhat difficult ❑ Not difficult at all	❑ Extremely difficult ❑ Somewhat difficult ❑ Not difficult at all
Did you consume any of these substances? How much? When?	❑ **Caffeine** Quantity _____ Time _____ ❑ **Alcohol** Quantity _____ Time_____	❑ **Caffeine** Quantity _____ Time _____ ❑ **Alcohol** Quantity _____ Time_____	❑ **Caffeine** Quantity _____ Time _____ ❑ **Alcohol** Quantity _____ Time_____	❑ **Caffeine** Quantity _____ Time _____ ❑ **Alcohol** Quantity _____ Time _____	❑ **Caffeine** Quantity _____ Time _____ ❑ **Alcohol** Quantity _____ Time_____	❑ **Caffeine** Quantity _____ Time _____ ❑ **Alcohol** Quantity _____ Time_____	❑ **Caffeine** Quantity _____ Time _____ ❑ **Alcohol** Quantity _____ Time_____
Sleep Aid Medication taken?	Sleep aid _____ Dose _____	Sleep aid _____ Dose _____	Sleep aid _____ Dose _____	Sleep aid _____ Dose _____	Sleep aid _____ Dose _____	Sleep aid _____ Dose _____	Sleep aid _____ Dose _____
Was your sleep disturbed by anything?							