

PULMONARY MEDICINE ASSOCIATES SLEEP CENTER

Please fill out this sleep log for any 7 consecutive days prior to your first consultation appointment with the physician.

Patient Name: _____

	DAY 1	Day 2	DAY 3	DAY 4	DAY 5	DAY 6	DAY 7
Please fill in the date:							
Did you nap? How long? How often? When?							
Did you consume any alcohol or non-prescribed medication? How much? When?							
Are you currently taking prescribed medication? What? How Much? When?							
Have you had any liquid specifically coffee, tea, or carbonated beverages other than water? What? How much? When?							
When did you get out of bed?							
How long did it take you to fall asleep?							
Did you wake up during the night? How many times? How long were you awake?							
What time was your final awakening?							
How did you feel upon awakening?							
What time did you get out of bed to start your day?							
How long did you sleep last night?							

Note: Please start each day after arising from bed in the morning.