CGH Main Clinic
101 E. Miller Road Sterling, IL 61081
(815) 632-5357

CGH Sleep Center
100 E. LeFevre Sterling, IL 61081
(815)564-4687/(815)625-0400 Ext 5687

Department of Sleep Medicine

Sleep Diary

Patient name: _____
(Please print)

Please complete this two-week diary the days preceding your scheduled sleep study.

Week 1

Day	Sun	Mon	Tue	Wed	Thu	Fri	Sat
Date							
Time you woke up.							
Time you got out of bed.							
Did you wake up Refreshed or Tired?	R or T	R or T	R or T	R or T	R or T	R or T	R or T
Number of naps taken throughout day.							
Time you went to bed.							
Approximate time you fell asleep							
Number of times awakened during the night							
Note duration of longest nap (minutes)							
Note any info affecting sleep for the day:							

Week 2

Day	Sun	Mon	Tue	Wed	Thu	Fri	Sat
Date							
Time you woke up.							
Time you got out of bed.							
Did you wake up Refreshed or Tired?	R or T	R or T	R or T	R or T	R or T	R or T	R or T
Number of naps taken throughout day.							
Time you went to bed.							
Approximate time you fell asleep							
Number of times awakened during the night							
Note duration of longest nap (minutes)							
Note any info affecting sleep for the day:							