Name:	
SLEEP LOG	

For two weeks before your appointment, please record the amount of time you spend either sleeping or attempting to sleep including naps on the grid. Record hours in bed and estimated hours asleep. List any medications or alcohol. Please bring this form with you when you visit the sleep clinic.

		PM AM Noon														Hours	Hours								
Date	Medications or Alcohol	9 1	0 11	12	1 2	2 3	4	5	6	7	8	9	10	11	1 12	2 1	2	3	4	5	6	7	8	in Bed	Asleep
June 26	1 Sleeping Pill, 1 oz. liquor		•		hou	rs in	be	d		•														8	6



AKN/St. Francis/Forms/Sleep Center/Sleep Log FCSL0556 Rev: 11/18/2009 Page 1 of 2 Patient ID Label or Write Name, Gender, DOB, Age, Admit Date, MR#, Acct#