

The **National Sleep Foundation** is dedicated to improving health and well-being through sleep education and advocacy. It is well-known for its annual Sleep in America® poll. The Foundation is a charitable, educational and scientific not-for-profit organization located in Washington, DC. Its membership includes researchers and clinicians focused on sleep medicine, health professionals, patients, families affected by drowsy driving and more than 900 healthcare facilities.

*[www.sleepfoundation.org](http://www.sleepfoundation.org)*



NATIONAL SLEEP  
FOUNDATION

# Sleep Diary

**S**ufficient sleep is important for your health, well-being and happiness. When you sleep better, you feel better. The National Sleep Foundation Sleep Diary will help you track your sleep, allowing you to see habits and trends that are helping you sleep or that can be improved.

## How to Use the National Sleep Foundation Sleep Diary

- ❖ Our sleep diary only takes a few minutes each day to complete.
- ❖ We've given you diary entries for seven days; you may want to make several copies.
- ❖ Review your completed diary to see if there are any patterns or practices that are helping or hindering your sleep. Is your bedroom a sanctuary for sleep? Or are there too many distractions? Did your nap interfere with a good night's sleep?
- ❖ Make incremental changes. Changing one habit at a time can set you on the path to healthy sleep.

Visit [sleepfoundation.org](http://sleepfoundation.org) for more sleep tips.

Complete in Morning							
Start date: __/__/__	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
Day of week:	_____	_____	_____	_____	_____	_____	_____
I went to bed last night at:	PM / AM	PM / AM	PM / AM	PM / AM	PM / AM	PM / AM	PM / AM
I got out of bed this morning at:	AM / PM	AM / PM	AM / PM	AM / PM	AM / PM	AM / PM	AM / PM
<b>Last night I fell asleep:</b>							
Easily	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
After some time	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
With difficulty	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>I woke up during the night:</b>							
# of times							
# of minutes							
<b>Last night I slept a total of:</b>							
Hours	Hours	Hours	Hours	Hours	Hours	Hours	Hours
<b>My sleep was disturbed by:</b> List mental or physical factors including noise, lights, pets, allergies, temperature, discomfort, stress, etc.							
<b>When I woke up for the day, I felt:</b>							
Refreshed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Somewhat refreshed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fatigued	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Notes:</b> Record any other factors that may affect your sleep (i.e. hours of work shift, or monthly cycle for women).							

Complete at the End of Day							
Day of week:	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
<b>I consumed caffeinated drinks in the:</b> (M)orning, (A)fternoon, (E)vening, (N/A)							
M / A / E / NA							
How many?	_____	_____	_____	_____	_____	_____	_____
<b>I exercised at least 20 minutes in the:</b> (M)orning, (A)fternoon, (E)vening, (N/A)							
<b>Medications I took today:</b>							
<b>Took a nap?</b> (circle one)							
Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
No	No	No	No	No	No	No	No
If Yes, for how long?							
<b>During the day, how likely was I to doze off while performing daily activities:</b> No chance, Slight chance, Moderate chance, High chance							
<b>Throughout the day, my mood was...</b> Very pleasant, Pleasant, Unpleasant, Very unpleasant							
<b>Approximately 2-3 hours before going to bed, I consumed:</b>							
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
A heavy meal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Caffeine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Not applicable	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>In the hour before going to sleep, my bedtime routine included:</b> List activities including reading a book, using electronics, taking a bath, doing relaxation exercises, etc.							