

# SLEEP DIARY

by **Dr. Mache Seibel**



WEEK OF:	DAY 1	DAY 2	DAY 3	DAY 4	DAY 5	DAY 6	DAY 7
Last night I went to bed at:	__:__ am/pm	__:__ am/pm	__:__ am/pm	__:__ am/pm	__:__ am/pm	__:__ am/pm	__:__ am/pm
How long did it take you to fall asleep?	____ hrs ____ mins	____ hrs ____ mins	____ hrs ____ mins	____ hrs ____ mins	____ hrs ____ mins	____ hrs ____ mins	____ hrs ____ mins
How many times did you wake up?	_____	_____	_____	_____	_____	_____	_____
What woke you up? (e.g. hot flashes)	_____ _____	_____ _____	_____ _____	_____ _____	_____ _____	_____ _____	_____ _____
How long did you sleep in total?	____ hrs ____ mins	____ hrs ____ mins	____ hrs ____ mins	____ hrs ____ mins	____ hrs ____ mins	____ hrs ____ mins	____ hrs ____ mins
When I woke up I felt (on a scale of 1 to 5)?	_1 (Not Rested) _2-3 (Neutral) _4-5 (Rested)	_1 (Not Rested) _2-3 (Neutral) _4-5 (Rested)	_1 (Not Rested) _2-3 (Neutral) _4-5 (Rested)	_1 (Not Rested) _2-3 (Neutral) _4-5 (Rested)	_1 (Not Rested) _2-3 (Neutral) _4-5 (Rested)	_1 (Not Rested) _2-3 (Neutral) _4-5 (Rested)	_1 (Not Rested) _2-3 (Neutral) _4-5 (Rested)
On a scale of 1 to 5, how did you feel over the next day?	_1 (Tired) _2-3 (Neutral) _4-5 (Energetic)	_1 (Tired) _2-3 (Neutral) _4-5 (Energetic)	_1 (Tired) _2-3 (Neutral) _4-5 (Energetic)	_1 (Tired) _2-3 (Neutral) _4-5 (Energetic)	_1 (Tired) _2-3 (Neutral) _4-5 (Energetic)	_1 (Tired) _2-3 (Neutral) _4-5 (Energetic)	_1 (Tired) _2-3 (Neutral) _4-5 (Energetic)
How satisfied are you with the quality of your sleep? (Check the option that best applies)	_1 (Dissatisfied) _2 (Somewhat) _3 (Neutral) _4 (Satisfied) _5 (Very)	_1 (Dissatisfied) _2 (Somewhat) _3 (Neutral) _4 (Satisfied) _5 (Very)	_1 (Dissatisfied) _2 (Somewhat) _3 (Neutral) _4 (Satisfied) _5 (Very)	_1 (Dissatisfied) _2 (Somewhat) _3 (Neutral) _4 (Satisfied) _5 (Very)	_1 (Dissatisfied) _2 (Somewhat) _3 (Neutral) _4 (Satisfied) _5 (Very)	_1 (Dissatisfied) _2 (Somewhat) _3 (Neutral) _4 (Satisfied) _5 (Very)	_1 (Dissatisfied) _2 (Somewhat) _3 (Neutral) _4 (Satisfied) _5 (Very)
One hour before bed I did the following:	_____ _____	_____ _____	_____ _____	_____ _____	_____ _____	_____ _____	_____ _____
In the 2-3 hours before bed I consumed:	<input type="checkbox"/> Alcohol <input type="checkbox"/> A Heavy Meal <input type="checkbox"/> Caffeine <input type="checkbox"/> Not Apply	<input type="checkbox"/> Alcohol <input type="checkbox"/> A Heavy Meal <input type="checkbox"/> Caffeine <input type="checkbox"/> Not Apply	<input type="checkbox"/> Alcohol <input type="checkbox"/> A Heavy Meal <input type="checkbox"/> Caffeine <input type="checkbox"/> Not Apply	<input type="checkbox"/> Alcohol <input type="checkbox"/> A Heavy Meal <input type="checkbox"/> Caffeine <input type="checkbox"/> Not Apply	<input type="checkbox"/> Alcohol <input type="checkbox"/> A Heavy Meal <input type="checkbox"/> Caffeine <input type="checkbox"/> Not Apply	<input type="checkbox"/> Alcohol <input type="checkbox"/> A Heavy Meal <input type="checkbox"/> Caffeine <input type="checkbox"/> Not Apply	<input type="checkbox"/> Alcohol <input type="checkbox"/> A Heavy Meal <input type="checkbox"/> Caffeine <input type="checkbox"/> Not Apply

This Sleep Diary is intended only as a tool to help you communicate with your doctor.

For more information on sleep, visit [www.DrMache.com](http://www.DrMache.com).