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.

Date	Medications or Alcohol	PM 9	10	11	AM 12	1	2	3	4	5	6	7	8	9	10	11	Noon 12	1	2	3	4	5	6	7	8	Hours in Bed	Hours Asleep
June 26	1 Sleeping Pill, 1 oz. liquor		●					hours in bed				●														8	6

ST. FRANCIS
Regional Medical Center

SLEEP LOG

Patient ID Label or Write Name, Gender, DOB, Age, Admit Date, MR#, Acct#