SLEEP DIARY

☐ **Sisters of Charity Hospital**
St. Joseph Campus
2605 Harlem Road
Cheektowaga, NY 14225

☐ **Kenmore Mercy Hospital**
2950 Elmwood Avenue
Kenmore, NY 14217

Patient's Name: **Appt. Date:** **Please start on:**

COMPLETE IN THE EVENING		Date:	Date:	Date:	Date:	Date:	Date:	Date:
QUESTION	EXAMPLE							
Did you have a nap today? How long did you sleep?	Yes, 60 minutes							
Did you have caffeine (coffee/cola)? How much?	Yes, 2 cups of coffee							
Did you have alcohol today? How much?	One beer with dinner							
Rate how alert you are on a scale of 1-10 (10 is completely alert)	4							

COMPLETE THE FOLLOWING MORNING		Date:	Date:	Date:	Date:	Date:	Date:	Date:
QUESTION	EXAMPLE							
What time did you go to bed?	11:00 PM							
How long did it take to fall asleep?	45 min.							
What time did you wake up this morning?	6:00 AM							
How many times did you wake up during the night?	Twice							
How many hours of sleep did you get last night?	6 ½ hours							
Rate your sleep on a scale of 1-10 (10 is completely refreshed)	6							

Please bring Sleep Diary with you on the night of your appointment