

Patient Name \_\_\_\_\_

Physician \_\_\_\_\_



**RALEIGH  
NEUROLOGY**  
ASSOCIATES, P. A.

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**SLEEP DIARY**

**COMPLETE WHITE SECTION IN THE MORNING.  
COMPLETE BLUE SECTION AT END OF DAY.**

	I went to bed last night at:	I got out of bed this morning at:	Last night, I fell asleep in:	I woke up during the night: [number of times]	When I woke up for the day, I felt: [check one]	Last night I slept a total of: [number of hours]	My sleep was disturbed by: [list any mental, emotional, physical or environmental factors that affected your sleep; e.g. stress, snoring, physical discomfort, temperature]	I consumed caffeinated drinks in the: [e.g. coffee, tea cola]	I exercised at least 20 minutes in the:	Approximately 2-3 hours before going to bed, I consumed:	Medication(s) I took during the day: [list name of medication/drug(s)]	About 1 hour before going to sleep, I did the following activity: [list activity; e.g. work, watch TV, read]
<b>DAY 1</b>					<input type="checkbox"/> Refreshed <input type="checkbox"/> Somewhat refreshed <input type="checkbox"/> Fatigued			<input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Within several hours of going to bed <input type="checkbox"/> N/A	<input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Within several hours of going to bed <input type="checkbox"/> N/A	<input type="checkbox"/> Alcohol <input type="checkbox"/> A heavy meal <input type="checkbox"/> N/A		
Day _____ Date _____	PM/AM	PM/AM	Minutes	Times		Hours						
<b>DAY 2</b>					<input type="checkbox"/> Refreshed <input type="checkbox"/> Somewhat refreshed <input type="checkbox"/> Fatigued			<input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Within several hours of going to bed <input type="checkbox"/> N/A	<input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Within several hours of going to bed <input type="checkbox"/> N/A	<input type="checkbox"/> Alcohol <input type="checkbox"/> A heavy meal <input type="checkbox"/> N/A		
Day _____ Date _____	PM/AM	PM/AM	Minutes	Times		Hours						
<b>DAY 3</b>					<input type="checkbox"/> Refreshed <input type="checkbox"/> Somewhat refreshed <input type="checkbox"/> Fatigued			<input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Within several hours of going to bed <input type="checkbox"/> N/A	<input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Within several hours of going to bed <input type="checkbox"/> N/A	<input type="checkbox"/> Alcohol <input type="checkbox"/> A heavy meal <input type="checkbox"/> N/A		
Day _____ Date _____	PM/AM	PM/AM	Minutes	Times		Hours						
<b>DAY 4</b>					<input type="checkbox"/> Refreshed <input type="checkbox"/> Somewhat refreshed <input type="checkbox"/> Fatigued			<input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Within several hours of going to bed <input type="checkbox"/> N/A	<input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Within several hours of going to bed <input type="checkbox"/> N/A	<input type="checkbox"/> Alcohol <input type="checkbox"/> A heavy meal <input type="checkbox"/> N/A		
Day _____ Date _____	PM/AM	PM/AM	Minutes	Times		Hours						
<b>DAY 5</b>					<input type="checkbox"/> Refreshed <input type="checkbox"/> Somewhat refreshed <input type="checkbox"/> Fatigued			<input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Within several hours of going to bed <input type="checkbox"/> N/A	<input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Within several hours of going to bed <input type="checkbox"/> N/A	<input type="checkbox"/> Alcohol <input type="checkbox"/> A heavy meal <input type="checkbox"/> N/A		
Day _____ Date _____	PM/AM	PM/AM	Minutes	Times		Hours						
<b>DAY 6</b>					<input type="checkbox"/> Refreshed <input type="checkbox"/> Somewhat refreshed <input type="checkbox"/> Fatigued			<input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Within several hours of going to bed <input type="checkbox"/> N/A	<input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Within several hours of going to bed <input type="checkbox"/> N/A	<input type="checkbox"/> Alcohol <input type="checkbox"/> A heavy meal <input type="checkbox"/> N/A		
Day _____ Date _____	PM/AM	PM/AM	Minutes	Times		Hours						
<b>DAY 7</b>					<input type="checkbox"/> Refreshed <input type="checkbox"/> Somewhat refreshed <input type="checkbox"/> Fatigued			<input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Within several hours of going to bed <input type="checkbox"/> N/A	<input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Within several hours of going to bed <input type="checkbox"/> N/A	<input type="checkbox"/> Alcohol <input type="checkbox"/> A heavy meal <input type="checkbox"/> N/A		
Day _____ Date _____	PM/AM	PM/AM	Minutes	Times		Hours						