Please complete this on a daily basis for seven consecutive days prior to your scheduled procedure.

Daily Sleep Log

Daily Sleep Log **Name:_____**	**Day 1** **Day _____** **Date __/___**	**Day 2** **Day _____** **Date _____**	**Day 3** **Day _____** **Date _____**	**Day 4** **Day _____** **Date _____**	**Day 5** **Day _____** **Date _____**	**Day 6** **Day _____** **Date _____**	**Day 7** **Day _____** **Date _____**
1. What time did you go to bed last night?							
2. How long did it take you to fall asleep?							
3. How many times did you wake up during the night? **a. Do you know why?** **b. How much time were you awake?**							
4. What time did you wake up this morning?							
5. What time did you get out of bed?							
6. How did you feel this morning?							
7. Did you nap today? **a. When?** **b. How long?**							
8. Are you now taking prescribed medication? **a. What?** **b. How much?** **c. When?**							
9. Have you had coffee, tea, or cola drinks today? **a. How much?** **b. When?**							
10. Have you had any alcohol today?							
11. Did anything unusual or stressful happen today?							