Do you have trouble sleeping? Do you feel tired during the day? Many Americans have sleep problems and often don't realize that these problems can be managed. To help identify what may be affecting your ability to get good sleep, record your sleep habits and experiences in this Sleep Diary.

How to Use the Sleep Diary

The Sleep Diary takes only a few minutes each day to complete. Keep it in a convenient place, such as on your bedside table. Complete the diary for 7 days, or copy it and use it for 2 weeks. Then, look over the diary to see if there are any patterns or issues that may be contributing to your sleep problems. Take the completed diary with you to your doctor's office to discuss any sleep problems you may be experiencing.

Get on the Road to Better Health

RECOGNIZING THE DANGERS OF SLEEP APNEA

Get on the Road to Better Health Sleep Diary

Fill out days 1–3 below and days 4–7 on back	COMPLETE IN MORNING							COMPLETE 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: *(Record number of times)*	When I woke up for the day, I felt: *(Check one)*	Last night I slept a total of: *(Record 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. watch TV, work, read)*
DAY 1 _____ DAY _____ DATE	_____ PM / AM	_____ PM / AM	_____ Minutes	_____ Times	❑ Refreshed ❑ Somewhat refreshed ❑ Fatigued	_____ Hours	_____	❑ Morning ❑ Afternoon ❑ Within several hours before going to bed ❑ Not applicable	❑ Morning ❑ Afternoon ❑ Within several hours before going to bed ❑ Not applicable	❑ Alcohol ❑ A heavy meal ❑ Not applicable	_____	_____
DAY 2 _____ DAY _____ DATE	_____ PM / AM	_____ PM / AM	_____ Minutes	_____ Times	❑ Refreshed ❑ Somewhat refreshed ❑ Fatigued	_____ Hours	_____	❑ Morning ❑ Afternoon ❑ Within several hours before going to bed ❑ Not applicable	❑ Morning ❑ Afternoon ❑ Within several hours before going to bed ❑ Not applicable	❑ Alcohol ❑ A heavy meal ❑ Not applicable	_____	_____
DAY 3 _____ DAY _____ DATE	_____ PM / AM	_____ PM / AM	_____ Minutes	_____ Times	❑ Refreshed ❑ Somewhat refreshed ❑ Fatigued	_____ Hours	_____	❑ Morning ❑ Afternoon ❑ Within several hours before going to bed ❑ Not applicable	❑ Morning ❑ Afternoon ❑ Within several hours before going to bed ❑ Not applicable	❑ Alcohol ❑ A heavy meal ❑ Not applicable	_____	_____

Get on the Road to Better Health Sleep Diary

Fill out days 4–7 below	COMPLETE IN MORNING							COMPLETE 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: *(Record number of times)*	When I woke up for the day, I felt: *(Check one)*	Last night I slept a total of: *(Record 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 the name of medication/drug(s)]*	About 1 hour before going to sleep, I did the following activity: *(List activity; e.g. watch TV, work, read)*
DAY 4 _____ DAY _____ DATE	_____ PM / AM	_____ PM / AM	_____ Minutes	_____ Times	❑ Refreshed ❑ Somewhat refreshed ❑ Fatigued	_____ Hours	_____	❑ Morning ❑ Afternoon ❑ Within several hours before going to bed ❑ Not applicable	❑ Morning ❑ Afternoon ❑ Within several hours before going to bed ❑ Not applicable	❑ Alcohol ❑ A heavy meal ❑ Not applicable	_____	_____
DAY 5 _____ DAY _____ DATE	_____ PM / AM	_____ PM / AM	_____ Minutes	_____ Times	❑ Refreshed ❑ Somewhat refreshed ❑ Fatigued	_____ Hours	_____	❑ Morning ❑ Afternoon ❑ Within several hours before going to bed ❑ Not applicable	❑ Morning ❑ Afternoon ❑ Within several hours before going to bed ❑ Not applicable	❑ Alcohol ❑ A heavy meal ❑ Not applicable	_____	_____
DAY 6 _____ DAY _____ DATE	_____ PM / AM	_____ PM / AM	_____ Minutes	_____ Times	❑ Refreshed ❑ Somewhat refreshed ❑ Fatigued	_____ Hours	_____	❑ Morning ❑ Afternoon ❑ Within several hours before going to bed ❑ Not applicable	❑ Morning ❑ Afternoon ❑ Within several hours before going to bed ❑ Not applicable	❑ Alcohol ❑ A heavy meal ❑ Not applicable	_____	_____
DAY 7 _____ DAY _____ DATE	_____ PM / AM	_____ PM / AM	_____ Minutes	_____ Times	❑ Refreshed ❑ Somewhat refreshed ❑ Fatigued	_____ Hours	_____	❑ Morning ❑ Afternoon ❑ Within several hours before going to bed ❑ Not applicable	❑ Morning ❑ Afternoon ❑ Within several hours before going to bed ❑ Not applicable	❑ Alcohol ❑ A heavy meal ❑ Not applicable	_____	_____

Congratulations! You have now taken the first step to managing your sleep problems. The FMSCA and NSF encourage you to take the next step by sharing this diary with your doctor.

There are many factors that affect the quality and duration of sleep and whether you feel fatigued during the day. In addition to reviewing your sleep diary, your doctor may take a medical history and refer you to a sleep specialist for a more complete examination.

For more information about sleep, visit NSF's Web site at www.sleepfoundation.org.

U.S. Department of Transportation
Federal Motor Carrier Safety Administration

National Sleep Foundation

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