Initials: ___________

Date: _____________

Evening Sleep Diary

1) **Did you nap for any period of time during the day?**
If yes, for a total of how much time? _____ Hours _____ Min

2) **On a scale of 0-5, how would you rate the following symptoms?** *(Check one box each)*

	0 (not at all)	1	2	3 (average)	4	5 (very)
Stressed						
Sleepy						
Fatigued						

3) **Please list any prescription medications, over the counter medications, or items taken for health reasons**

What	Number (dose)	Times(s) of day	For what purpose
Ex: Ibuprofen	*2 (200 mg)*	*7am*	*Headache*

Were any of these taken to increase your energy level? Which? __________________
Were any of these taken to decrease your energy level? Which? __________________

4) **Please list any alcoholic beverages that you may have had today**

What	When/Time	How Much
Ex: Martini	*Dinner/ 6pm*	*1 glass*

Was this a typical amount for you per day, less, or more? ____ Typical ____ Less ____ More

5) **Please list any products containing nicotine that you may have had today**

What	When/Time	How Much
Ex: Nicorette Gum 2mg	*Once every 2 hours*	*8 pieces*

Was this a typical amount for you per day, less or more? ____ Typical ____ Less ____ More

6) **Please list any products containing caffeine (or other stimulants)**

What	When/Time	How Much
Ex: Coffee	*Morning, lunch / 6am, 12pm*	*1 cup each time*

Was this a typical amount for you per day, less or more? ____ Typical ____ Less ____ More

7) **About how much time did you spend NOT sitting or lying down today?** ____ Hours ____ Minutes

8) **About how much time did you spend doing something that caused you to be out of breath or sweat?**
____ Hours ____ Minutes

9) **Was today in any way unusual for you?** ____ Yes ____ No. *If yes, please explain:*_________________
____
____