DELTA DENTAL®

Sleep Diary

ANSWER after you get up.*	SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
I went to bed at:	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM
I fell asleep at:	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM
I woke up at:	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM
I slept: (how many hours)	hours	hours	hours	hours	hours	hours	hours
How often did you wake up during sleep?	times	times	times	times	times	times	times
My stress level was 1-10 (1=low, 10=high)							
I exercised yesterday. List time you started, how long and exercise type.	Start Length Type	Start Length Type	Start Length Type	Start Length Type	Start Length Type	Start Length Type	Start Length Type
I had caffeine and/or alcohol yesterday. List type(s) and time(s), and number of drinks.	Type Time Number	Type Time Number	Type Time Number	Type Time Number	Type Time Number	Type Time Number	Type Time Number
If you use tobacco, list type (cigarettes, chew, etc.) amount and times used.	Type Amount Times	Type Amount Times	Type Amount Times	Type Amount Times	Type Amount Times	Type Amount Times	Type Amount Times
I took a nap yesterday.	AM PM minutes	AM PM minutes	AM PM minutes	AM PM minutes	AM PM minutes	AM PM minutes	AM PM minutes
List any medications you took yesterday.							
List what you did 1 to 2 hours before going to sleep (smartphone use, etc.)							

**Use this form to record your sleep habits and identify factors which may interfere with your sleep. Share your sleep diary with your health care provider.*

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