Sleep Management Institute

PATIENT REGISTRATION

(Please Print)

Patient Name: ______________________________ Birth Date: ____-____-____ Age: _____
(Last) (First) (MI)

SSN: ______-______-______ Sex: ☐Male ☐Female Marital Status: ☐S ☐M ☐D ☐W ☐Sep ☐DP

Address: ____
(Street) (City) (State) (Zip)

Phone: (______) _______-________ (______) _______-________ (______) _______-________
(Home) (Mobile) (Work)

Email Address: ________________________________ ☐ Please do not send me email updates

Employer: ___________________________ Address: ______________________________
(Street) (City) (State) (Zip)

Referred By: ______________________________ Phone #: (______) _______-________
(Last) (First)

Primary Care MD: __________________________ Phone #: (______) _______-________
(Last) (First)

Primary Insurance: ________________________ Phone #: (______) _______-________

Address: ____

I.D. #: _________________________________ Group #: ___________________________

Insured's Name: _______________________ DOB: ____-____-____ SSN: ____-___-_____

Relationship to Patient: __________________ Insured's Employer: ____________________

Employer's Address: ______________________ Phone #: (______) _______-________

Secondary Insurance: ______________________ Phone #: (______) _______-________

Address: ____
(Street) (City) (State) (Zip)

I.D. #: _________________________________ Group #: ___________________________

Insured's Name: _______________________ DOB: ____-____-____ SSN: ____-___-_____

Relationship to Patient: __________________ Insured's Employer: ____________________

Employer's Address: ______________________ Phone #: (______) _______-________

Emergency Contact: Name: _____________________________ Relationship: __________

Address: ____
(Street) (City) (State) (Zip)

Home Phone #: (______) _______-__________ Work #: (______) _______-________

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1) I hereby give consent to Sleep Management Institute to:

- Render testing and treatment.
- Use and disclose my Protected Health Information for purposes of treatment, payment and health care operations as outlined in our Notice of Privacy Practices for Protected Health Information.
- Act as my agent in helping obtain payment from my insurance company(s).
- Receive payments directly from my insurance company(s).

2) I authorize Optimum Sleep Associates to act as an agent for Sleep Management Institute to use and disclose my Protected Health Information for the purpose of arranging durable medical equipment or other treatment as necessary.

3) I understand that I am responsible for all charges incurred, even if they are not covered by my insurance plan, and verifying whether or not Sleep Management Institute is a covered facility in my insurance plan.

Patient Signature (or Representative): ___________________________ Date: ____-____-____

Print Representatives Name: ___________________________ Relationship: ______________

Sleep Management Institute

Sleep History Questionnaire

Patient Name: ______________________________ **DOB:** __________ **Date:** __________

Please complete the following questionnaire with input from your bed partner if possible. If certain questions do not apply, indicate "N/A." Your answers will be strictly confidential.

1. Please describe your problem(s) related to sleep/sleepiness. ______________________________

____

____

2. How long have you had this problem? number of... _____weeks _____months _____years
3. Is your sleep problem: ☐ getting worse ☐ getting better ☐ staying the same
4. Have you had a previous sleep disorder evaluated or treatment? ☐ Yes ☐ No
   - If yes, were you diagnosed with a sleep disorder? ☐ Yes - what disorder: ______________ ☐ No
   - When were you diagnosed: ______________ / Where: ______________________
     - What sleep disorder treatments have you had:
       - ☐ CPAP/BPAP - Are you still using CPAP/BPAP? ☐ Yes ☐ No
       - ☐ oral device ☐ oxygen #_____ liters ☐ behavior therapy
       - ☐ medication - what meds: ______________________________
       - ☐ other: ______________________________________
5. The following questions pertain to your usual sleep schedule:

	Usual Schedule	Weekend or Off Days
Usual bedtime:	________am/pm	________am/pm
Lights off time:	________am/pm	________am/pm
Typical amount of time it takes to fall asleep:	________min	________min
Typical number of times that you awaken during sleep:	__________	__________
Typical reason that you awaken during sleep:	__________	__________
Typical number of times that you awaken to use the restroom:	__________	__________
Typical final wake-up time from sleep:	________am/pm	________am/pm
How many hours of sleep do you get on average:	________hrs	________hrs
Do you use an alarm to awaken:	☐ Yes ☐ No	☐ Yes ☐ No
How do you typically feel when you wake up:	☐ rested ☐ tired ☐ sleepy	☐ rested ☐ tired ☐ sleepy

6. Do you:
   - ☐ watch TV or listen to music in bed
   - ☐ work 3rd shift or rotating shifts
   - ☐ travel across times zones for work
7. Do you have any of the following job requirements:
   - ☐ driving a vehicle
   - ☐ work with dangerous equipment or substances
   - ☐ work with hazardous materials or in hazardous situations
8. How would you describe your sleep quality (*check all that apply*)?
   - ☐ excellent ☐ very good ☐ fair ☐ poor ☐ very poor
   - ☐ sound sleep ☐ restless ☐ very restless ☐ sleep is very disrupted

9. Do you have difficulty: ☐ falling asleep ☐ staying asleep
   - If yes:
     - how long? number of... _____weeks _____months _____years
     - how often? ☐ every day ☐ most days ☐ occasional
     - list any contributing reasons for this problem: ____________________
     - how do you feel during the day? ☐ usually tired ☐ usually alert
     - typical amount of time that you are in bed unable to sleep: _______hrs
     - typical time it takes to fall back asleep after awakening: _______hrs ***or*** ☐ often unable to return to sleep
     - when unable to sleep, do you do any of the following:
       ☐ use restroom ☐ watch TV or listen to music in bed ☐ eat
       ☐ worry at night ☐ other ____________________
     - describe any problems in your sleeping environment:
       ☐ noisy sleep environment ☐ bed partner ☐ excessive light
       ☐ uncomfortable temperature ☐ pet interference ☐ uncomfortable bed
       ☐ other ____________________

10. Do you have a problem with daytime sleepiness, drowsiness or fatigue? ☐ Yes ☐ No
    - If yes:
      - how long? number of... _____weeks _____months _____years
      - how often? ☐ every day ☐ most days ☐ occasional
      - what time of day: ☐ morning ☐ afternoon ☐ evening ☐ all day
      - do you doze off unintentionally during the day? ☐ Yes ☐ No
      - have you fallen asleep:
        ☐ while driving ☐ during conversations ☐ at work or school
        ☐ when sedentary ☐ while watching TV during the day
        ☐ while standing ☐ while walking ☐ during sex

11. Have you had sleep related:
    ☐ marital or social problems ☐ job errors or reprimands ☐ job change
    ☐ accident or injury ☐ poor school performance ☐ drug or alcohol abuse

12. Do you take naps? ☐ Yes ☐ No
    - If yes:
      - how often? ☐ every day ☐ most days ☐ occasional
      - what time(s): _______am/pm _______am/pm _______am/pm
      - how long is your typical nap (*give range if variable*)? _______hrs
      - how do you typically feel after a nap: ☐ rested ☐ tired
      - do you dream during your naps? ☐ Yes ☐ No

13. Do you have any problems with: (*check all that apply*)
    ☐ body movements ☐ had broken nose ☐ allergies
    ☐ leg movements ☐ nasal congestion ☐ had tonsillectomy
    ☐ restlessness ☐ use nasal spray ☐ impotence
    ☐ morning dry mouth ☐ had nose or sinus surgery ☐ acid reflux or indigestion at night
    ☐ morning headaches

14. Do you snore? ☐ Yes ☐ No
    - If yes, characterize your snoring: (*check all that apply*)
      ☐ soft ☐ moderate ☐ loud ☐ very loud
      ☐ intermittent ☐ continuous
      ☐ worse on back ☐ present in all positions ☐ bothers bed partner

15. Do you awaken from sleep: (*check all that apply*)
    ☐ choking ☐ with smothering sensation ☐ gasping for air ☐ with shortness of breath

16. Has anyone ever commented that you stop breathing while you sleep? ☐ Yes ☐ No

17. Do you ever experience a sudden weakness in your muscles associated with emotional situations (laughter, surprise, excitement, anger, etc.)? ☐ Yes ☐ No

18. Do you ever hallucinate (hear, see, or feel things that are not real) just as you are dozing off or immediately upon awakening? ☐ Yes ☐ No

19. Have you felt unable to move (paralyzed) for a few seconds when you are falling asleep or as you are waking up? ☐ Yes ☐ No

20. Do your legs kick, twitch or move at night while you are sleeping? ☐ Yes ☐ No

21. Do you feel burning or discomfort (aches or cramps) in your legs or feet? ☐ Yes ☐ No
    - If yes, does your leg or feet discomfort interfere with your sleep? ☐ Yes ☐ No

22. Do your legs ever have a "creepy crawly" feeling or general feeling of uneasiness while sitting or lying quietly that causes an almost irresistible urge to move your legs? ☐ Yes ☐ No
    - If yes, - what time of day: ☐ morning ☐ afternoon ☐ evening ☐ all day
      - rate the severity of this feeling: ☐ mild ☐ moderate ☐ severe
      - does this feeling feel better with: (*check all that apply*)
        ☐ moving your legs ☐ walking ☐ stretching ☐ standing ☐ Other ________
      - does this feeling in your legs interfere with your sleep? ☐ Yes ☐ No

23. Do you do any of the following while you are sleeping: (*check all that apply*)
    ☐ walk in your sleep
    ☐ talk in your sleep
    ☐ act out your dreams
    ☐ wet the bed
    ☐ have frequent arousals or awakenings
    ☐ have recurrent nightmares
    ☐ grind your teeth
    ☐ have palpitations when you awaken
    ☐ have shortness of breath
    ☐ other________________________________

Past Medical History:

Check any medical problems that you have received treatment for by a health care provider:

- O No known problems
- O Anemia
- O Angina
- O Anxiety
- O Asthma
- O Atrial Fibrillation
- O Atrial Flutter
- O Autoimmune Disorder
- O Bipolar Disorder
- O Brain Tumor
- O Breast cancer
- O Cirrhosis
- O Colon Cancer
- O CHF (Heart Failure)
- O COPD (Emphysema)
- O Coronary Heart Disease
- O Chronic Renal Failure
- O Crohn's Disease
- O CVA (Stroke)
- O Depression
- O Deviated septum
- O Diabetes Type: o I o II
- O Diverticulitis
- O Endocarditis
- O Erectile Dysfunction
- O Fibromyalgia
- O GI Bleed
- O GERD (Reflux)
- O Gout
- O Headaches
- O Heart Block
- O Heart defibrillator
- O Hepatitis:
  - Type: o A o B o C
- O High Cholesterol
- O HIV
- O Hypertension
- O Hypothyroidism
- O Kidney Disease
- O Liver Disease
- O Hay fever
- O Heart Attack (MI)
- O Hiatal Hernia
- O Irritable Bowel Syndrome
- O Leukemia/lymphoma
- O Lung cancer
- O Osteoarthritis
- O Osteoporosis
- O Pacemaker
- O Pancreatitis
- O Paralysis
- O Parkinson's disease
- O Polycystic ovarian syndrome
- O Peptic Ulcer Disease
- O Prostate cancer
- O Prostate problems
- O Pulmonary Embolism
- O Rheumatoid arthritis
- O Seizure Disorder
- O SVT (Tachycardia)
- O Syncope
- O Thyroid Disorder
- O Tuberculosis
- O Vascular Disease (PVD)
- O Other:______________
- O Other:______________

Surgical History:

Check any surgeries that you have had:

- O No Surgery
- O Abdominal Surgery
- O Amputation
- O Aortic Valve Replacement
- O Appendectomy
- O Back Surgery
- O Breast surgery
- O CABG (Coronary Bypass)
- O Carotid Endarterectomy
- O Carpal Tunnel
- O Cholecystectomy (Gall Bladder)
- O Caesarean section
- O Cataract Surgery
- O Colon Surgery
- O Gastric Bypass/ Lap Band
- O Hemorrhoidectomy
- O Hip Replacement
- O Knee Arthroscopy
- O Eye/cataract surgery
- O Knee Replacement
- O Hernia Repair
- O Hysterectomy
- O Mastectomy
- O Mitral Valve Replacement
- O Nasal/Sinus surgery
- O Nephrectomy
- O Pacemaker
- O Parathyroidectomy
- O Plastic surgery
- O Pneumonectomy
- O Prostate surgery
- O PTCA (Angioplasty)
- O Rotator Cuff Repair
- O Tonsillectomy
- O UPPP
- O Urinary Incontinence Surgery
- O Vertebroplasty
- O Anesthesia Problem - No
- O Anesthesia Problem - Yes
- O Other:______________
- O Other:______________
- O Other:______________
- O Other:______________

Medications: (please list all current medications and the dosage):

1. ______________ 2. ______________ 3. ______________
4. ______________ 5. ______________ 6. ______________
7. ______________ 8. ______________ 9. ______________
10. ______________ 11. ______________ 12. ______________

Allergies: ________________________________

Risk Factors:

Tobacco use: ☐ Currently ☐ Previously ☐ Never Year started using tobacco: __________

Tobacco use per day: Cigarettes: _____packs Cigars: _____#/day Smokeless/chew: _____amt/day

Passive smoke exposure (second hand smoke): ☐ Yes ☐ No

Alcohol: Do you drink alcohol: ☐ Yes ☐ No

Average number or alcoholic drinks per day: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐4 ☐ 4+

Do you use any of the following recreation drugs? ☐ Yes ☐ No What: ______________

Recreation drug use: ☐ Daily ☐ Weekly ☐ Monthly ☐ Less than once a month

How often do you exercise per week: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 7+

Do you consume caffeine? ☐ Yes ☐ No If yes, what: ______________________

Amount per day: ______________________

Do you consume caffeine in order to combat sleepiness and/or fatigue? ☐ Yes ☐ No

Social History:

Occupation: ______________________ Where Employed: ______________

Job Duration: _____years Military Experience? ☐ Yes ☐ No Combat Experience? ☐ Yes ☐ No

Education Level:

☐ < 7th Grade ☐ 7th Grade ☐ 8th Grade ☐ 9th Grade ☐ 10th Grade ☐ 11th Grade

☐ Partial College ☐ College Graduate ☐ Post-Graduate Level ☐ Doctorate

Hobbies/Interest: ________________________________

Do you live with: ☐ spouse ☐ child ☐ parents ☐ friend ☐ relative ☐ guardian
☐ professional care giver ☐ no one

Do you live at: ☐ home ☐ retirement community ☐ nursing home
☐ friend/relative home ☐ parent home

Marital Status: ☐ Married ☐ Divorced ☐ Single ☐ Widowed

Years Married: _______ Number of children: ________

Height _____ feet _____ inches Neck Size: ___________ inches

Current weight _____ lbs. Weight one-year ago _____ lbs. Maximum weight _____ lbs.

Do you sleep alone? ☐ Yes ☐ No

Family Medical History:

Do you know of any blood relative that has or had a sleep disorder or other illness?

	Fam Member		Fam Member		Fam Member
o Snoring	____	o Emphysema	____	o Anxiety	____
o Sleepiness	____	o Asthma	____	o Cancer	____
o Sleep apnea	____	o Heart Disease	____	o Diabetes	____
o Thyroid Disease	____	o High Blood Press	____	o Stroke	____
o Alzheimer's	____	o Epilepsy or Seizure	____	o Sleepwalking	____
o Narcolepsy	____	o Restless legs	____	o Insomnia	____
o Depression	____	o Alcohol Abuse	____	o Other	____

Parents living? Mother: ☐ Yes ☐ No - Died of ____________________

Father: ☐ Yes ☐ No - Died of ____________________

Review of Systems: Do you have/had any of the following problems? *Check all that apply or Denies All*

General

O Chills
O Appetite loss
O Fever
O Night sweats
O Weight gain over past year
O Fatigue
O Frequent Headaches
O Weight loss
O **Denies all**

Eyes

O Discharge
O Cataracts
O Blurring
O Eye Pain
O Impaired vision – 1 eye
O Double vision
O Floppy eyelids
O Impaired vision – both eyes
O Irritation
O Require glasses
O Light sensitivity
O **Denies all**

Ears/Nose/Throat

O Ringing in ears
O Nose bleeds
O Jaw joint pain
O Choking on food
O Sore throat
O Earache
O Hearing loss
O Hoarseness
O Ear discharge
O Nasal congestion
O Trouble swallowing
O **Denies all**

Cardiovascular

O Palpitations
O Leg cramps with exertion
O Lightheadedness
O Shortness of breath while lying flat
O Chest pain
O Passing out or fainting
O Shortness of breath with exertion
O Skipped heart beats
O Swelling in hands or legs
O Heart racing
O **Denies all**

Respiratory

O Chronic cough
O Excessive sputum
O Coughing up blood
O Shortness of breath
O Wheezing
O Chest discomfort
O **Denies all**

Gastrointestinal

O Constipation
O Excessive appetite
O Nausea
O Vomiting blood
O Vomiting
O Abdominal pain
O Blood in or black stools
O Diarrhea
O Acid reflux
O Change in bowel habits
O Abdominal bloating
O Indigestion
O Yellowish skin color
O **Denies all**

Genital/Urinary

O Urinary incontinence
O Frequent urination
O Diminished urinary stream
O Burning with urination
O Lack of sexual drive
O Abnormal vaginal pain
O Blood in urine
O Nighttime urination
O Trouble starting urination
O Kidney pain
O Urinary urgency
O Penile/pelvic pain
O **Denies all**

Review of Systems (continued):

Musculoskeletal			
O Joint stiffness	O Neck pain	O Loss of strength	O Arthritis
O Muscle pain	O Back pain	O Joint pain	O **Denies all**
O Joint swelling	O Muscle cramps	O Muscle weakness	

Skin			
O Itching	O Dryness	O Rash	O Hx of skin cancer
O Poor wound healing	O Suspicious lesions	O Changes in skin color	O **Denies all**

Neurologic			
O Transient paralysis	O Headaches	O Loss of consciousness	O Tingling sensation
O Dizziness	O History of head trauma	O Tremors	O Memory loss
O Difficulty speaking	O Seizures	O Falling down	O Fainting
O Numbness in legs/arms	O Poor balance	O Difficulty with concentration	O **Denies all**

Psychiatric			
O Memory loss	O Obsessive thoughts	O Impaired concentration	O Thoughts of violence
O Paranoia	O Depression	O Anxiety/nervousness	O **Denies all**
O Suicidal thoughts	O Mental problems	O Hallucinations	

Endocrine			
O Intolerance to cold	O Excessive liquid consumption	O Excessive thirst	O Excessive urination
O Excessive hunger	O Intolerance to heat	O Thyroid problem	O Hot flashes
		O Post menopausal	O **Denies all**

Hematologic/Lymphatic			
O Abnormal bruising	O Abnormal bleeding tendency	O Enlarged lymph nodes	O **Denies all**
		O History of anemia	

Allergy/Immunologic		
O Frequent infections	O Hives	O HIV exposure
O Hay fever/nasal allergies	O Chronic fatigue syndrome	O **Denies all**

Patient (or Guardian) Signature: ______________________________ Date: ___________

Relationship: ____________________

Reviewed by Physician: ____________________________________ Date: ___________

SLEEP MANAGEMENT INSTITUTE

THE EPWORTH SLEEPINESS SCALE

Name: ____ Sex: ________

Today's date: ____________________ Your age: ____________

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you. Use the following scale to choose the most appropriate number for each situation:

0 = would never doze
1 = slight chance of dozing
2 = moderate chance of dozing
3 = high chance of dozing

Situation	**Chance of Dozing**
Sitting and reading	________
Watching TV	________
Sitting, inactive in a public place (e.g., a theater or a meeting)	________
As a passenger in a car for an hour without break	________
Lying down to rest in the afternoon when circumstances permit	________
Sitting and talking to someone	________
Sitting quietly after a lunch without alcohol	________
In a car, while stopped for a few minutes in traffic	________
TOTAL	________

Thank you for your cooperation

SLEEP MANAGEMENT INSTITUTE

Pre Study Assessment

Pt Name: ______________________ DOB: __________ Weight: ________

Please answer the following questions related to your current condition: ✓ *Check all that apply*

- O I can function independently and require no assistance.
- O I use a cane or walker, but do not need someone to help me walk.
- O I need assistance to get in and out of bed and/or to walk.
- O I need assistance completing paperwork.
- O I use a wheelchair.
- O I am confined to bed.
- O I need a handicapped equipped restroom.
- O I must sleep in a recliner.
- O I have significant O visual / O hearing impairment and require someone's assistance.
- O I have significant mental or psychological impairment, and require someone's assistance.
- O I have a chronic or serious medical condition? Explain:______________________
- O I have been hospitalized within the last 3 months. Explain:______________________
- O I suffer from incontinence or bed wetting.
- O I use a transportation services? Name of service:__________________ Ph:__________
- O I use oxygen at home. ______ liters per minute. O Continuous O Daytime Only O Nighttime only

Do you have any other special or unusual circumstances? Explain: ______________________

____

DO NOT WRITE BELOW THIS LINE

To Be Completed By SMI Staff.

- ☐ **0** - Functions independently - verified no special circumstances.
- ☐ **1** - Deviation in arrival time ____________ / departure time __________ **Alert Day Tech*
- ☐ **1** - Someone is staying w patient – evaluate circumstances **Alert Day Tech* ☐ Needs cot ☐ Needs extra room
- ☐ **1** - Sleeps in recliner – evaluate circumstances **Alert Day Tech*
- ☐ **1** - Significant medical conditions, but does not affect scheduling. (i.e. Heart Disease, MI, CVA, Pacemaker)
- ☐ **1** - Incontinence or Enuresis - Needs: ☐ Urinal ☐ Bed Pads **Alert Day Tech*
- ☐ **1** - Assistance ambulating **Alert Day Tech*
- ☐ **2** - Handicapped equipped room needed – evaluate circumstances **Alert Day Tech*
- ☐ **2** - Wheelchair **- SOMEONE MUST STAY WITH PATIENT** **Alert Day Tech*
- ☐ **2** - Significant visual / hearing impairment **- SOMEONE SHOULD STAY WITH PATIENT** **Alert Day Tech*
- ☐ **3** - Pt. weighs $\geq$ 400 lbs. **IF CPAP, ONLY SCHEDULE WITH 2 NPSGs** **Alert Day Tech*
- ☐ **2** - Uses special transportation: **Alert Day Tech*
- ☐ **3** - Bedridden **- SOMEONE MUST STAY WITH PATIENT** **Alert Day Tech*
- ☐ **3** - Significant mental or psychological impairment **- SOMEONE MUST STAY WITH PATIENT** **Alert Day Tech*
- ☐ **3** - Significant respiratory related medical conditions (i.e. COPD, CHF, Neuromuscular disease). **Alert Day Tech*
- ☐ **3** - On oxygen: ______ liters per minute. ☐ Continuous ☐ Daytime Only ☐ Nocturnal
- ☐ Other Special Circumstances: ______________________________ **Alert Day Tech*

☐ **NPSG-0** - No complications	☐ **CPAP-0** - Can schedule with other Titration	
☐ **NPSG-1** - Possible complications	☐ **CPAP-1** - Special circumstances	
☐ **NPSG-2** - Known complications	☐ **CPAP-3** – Avoid scheduling with other titration	
☐ **NPSG-3** - High risk patient		

O Patient can be scheduled with no assistance.

O Patient will bring required assistance

O Patient cannot arrange required assistance. Alternate testing arrangements must be made.

Staff:______________________ Date:______________

SLEEP MANAGEMENT INSTITUTE

Two Week Sleep Diary

Patient Name: ______________________________

DOB: ____________________ Date: ____________________

Keys to Symbols

Symbol		Meaning	Symbol		Meaning
↓	=	In Bed (Tried to Sleep)	**S**	=	Sedative
↑	=	Out Of Bed	**M**	=	Other Medication
—	=	Asleep	**A**	=	Alcohol
/	=	Brief Awakening	**X**	=	Exercise
			D	=	Excessive Drowsiness

	DAY	DATE	MN	1am	2am	3am	4am	5am	6am	7am	8am	9am	10am	11am	NOON	1pm	2pm	3pm	4pm	5pm	6pm	7pm	8pm	9pm	10pm	11pm
SAMPLE	M	3/23	—	—	—/—	—/—	—	—	↑			M	X	X		M	D	—		M				S	↓—	—
	T	3/24	—	—	—	///	↑					—		X			D	—	—		M		A	A	↓—	—

DAY	DAY	DATE	MN	1am	2am	3am	4am	5am	6am	7am	8am	9am	10am	11am	NOON	1pm	2pm	3pm	4pm	5pm	6pm	7pm	8pm	9pm	10pm	11pm
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14																										

Directions on Reverse Side

OVER →

Each Day, Do The Following:

1) Write the day and date.
2) Draw an arrow pointing down (↓) at the time that you tried to go to sleep.
3) Draw a horizontal line (—) at the time that you were asleep, including naps.
4) Draw a slash (/) through the horizontal line for each brief awakening.
5) Draw an arrow pointing up (↑) at the time that you got out of bed.
6) Mark the times that you took a sedative or sleeping pill with a "**S**".
7) Mark the times that you took other medication with a "**M**".
8) Mark the times that you consumed alcohol with an "**A**".
9) Mark the times that you exercised with a "**X**".
10) Mark the times that you experienced excessive drowsiness or sleepiness with a "**D**".