Jamil S. Sulieman, M.D., Inc.
Pulmonary and Sleep Medicine

THE SLEEP LAB OFFICE
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Patient Name _____ DOB _____ Date Started _____

* **If you Slept.....**

WEEKLY SLEEP LOG

DATES:								
	Example	**MON**	**TUES**	**WED**	**THURS**	**FRI**	**SAT**	**SUN**
What time did you go to bed?	*11:30p*							
What time did you turn the lights off to go to sleep?	*11:45p*							
About how long did it take you to fall asleep? (15 mins, ½, 1, 2 hrs etc.)	*10 mins*							
How many times did you wake up during the night?	*3*							
About how long were you awake during the night? (Add total time of all awakenings – 15 mins, ½, 1, 2 hrs etc.)	*30 mins*							
What time did you wake up this morning?	*6:00a*							
What time did you get out of bed?	*6:35a*							
About how many hours did you sleep last night?	*5 hrs*							
Did you take a sleep medication? Indicate dose and medication name	*no*							
What time did you take the medication?	*10:00p*							

- **PLEASE MAKE SURE TO FILL ALL BOXES OUT WITH ACCURATE TIMES**