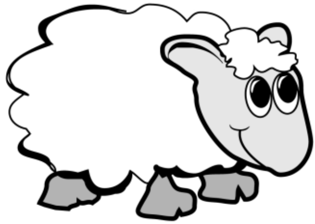
# Deaconess Sleep Center



## PEDIATRIC TWO- WEEK SLEEP LOG

Phone: (812) 450-3852 Fax: (812) 450-3994

Patient Name: ________________________________________ Date of Birth____________________________

**INSTRUCTIONS:** Complete the logs in the morning and the evening. Do not complete the logs during the night. Write any additional comments on the back of the sleep log. Please mark all times including daytime naps.

1. Leave awake time BLANK
2. ARROW DOWN (↓) whenever you lie down to sleep and ARROW UP (↑) when up awaken, including naps.
3. SHADE sleep time in between. **Enter "C" for Caffeine drinks **

EXAMPLE:

| Date | 6am | | 8am | | 10am | | Noon | | 2pm | | 4pm | | 6pm | | 8pm | | 10pm | | MN | | 2am | | 4am | 6am |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 12/15/09 | | ↑ | | | | | | | C | | | | | | | ↓ | | | | | | | | |

## FIRST WEEK

| Date | 6am | | 8am | | 10am | | Noon | | 2pm | | 4pm | | 6pm | | 8pm | | 10pm | | MN | | 2am | | 4am | 6am |
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## SECOND WEEK

| Date | 6am | | 8am | | 10am | | Noon | | 2pm | | 4pm | | 6pm | | 8pm | | 10pm | | MN | | 2am | | 4am | 6am |
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Medications Taken: ______________________________________________________________

**YOU MUST BRING THIS SLEEP LOG WITH YOU TO YOUR APPOINTMENT OR MAIL THEM TO THE SLEEP CENTER.**