Premier Lung & Sleep Specialists

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Sleep Log

Name: _____ **DOB:** _____

Please shade in the times that you sleep (*example below*), including any naps. If you wake up at night, do not shade in that area.

Medication List *(used to help sleep)*: _____

Any alcohol intake? ❑ Yes ❑ No

Day/Date		12p	1p	2p	3p	4p	5p	6p	7p	8p	9p	10p	11p	12p	1a	2a	3a	4a	5a	6a	7a	8a	9a	10a	11a
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