MIDUS BIOMARKER PROJECT: DAILY SLEEP DIARY

TUESDAY DATE:_____________

BEFORE BED: (Please complete the following before going to sleep).

1. How alert were you today? (circle a number):  most alert  1   2   3   4   5  not alert at all
2. How many minutes of moderate or vigorous exercise did you get today? ________
3. Did you nap today?  Yes   No   If yes, specify length of time: ________ (minutes)
4. How many caffeinated drinks did you have today? ___________ #of drinks
   (Note: 1 mug of coffee or cup of tea, 1 can pop = 1 drink)
5. How many alcoholic drinks did you have today? ____________  #of drinks
   (Note: 1 bottle beer or wine cooler, 1 glass of wine, 1 shot of liquor = 1 drink)
6. Did you take any medications today that you don’t regularly take every day?  Yes   No
   (e.g. allergy or cold medicine, pain relievers, etc.)
   If yes, record the medication name(s) and dose(s): _________________________________________

WEDNESDAY MORNING

UPON AWAKENING: (Please complete soon after waking up, waiting no more than 10 minutes).

7. Did you take any medication or supplement specifically to help you sleep?  Yes   No
   If yes, please record the medication name and dose: ______________________________
8. What time did you go to bed and begin trying to go to sleep? _____:______ a.m./p.m.
9. How long did it take you to get to sleep last night?  _______ (minutes)
10. How difficult was it to get to sleep last night? (circle a number)  very easy  1   2   3   4   5  very difficult
11. How many times did you wake last night (after falling asleep but before your final awakening)? ___
12. Did you wake up because of noises, lights, or some other activity?  Yes   No
13. If you woke up during the night, did you have difficulty getting back to sleep?  Yes   No
14. If you woke up during the night, during how many of these awakenings did you get out of bed? ___
15. What time did you wake up for the day and not return to sleep?  _____:_____ a.m./p.m.
16. What time did you get out of bed for the day?  _____:_____ a.m./p.m.

Please rate the following: (circle a number)

17. How deeply you slept last night:  very deeply  1   2   3   4   5  very lightly
18. How well-rested you feel this morning:  well rested  1   2   3   4   5  poorly rested
19. How alert you feel this morning:  very alert  1   2   3   4   5  not alert at all
20. Overall quality of your sleep last night:  very good  1   2   3   4   5  very poor
BEFORE BED: (Please complete the following before going to sleep).

1. How alert were you today? (circle a number): most alert 1 2 3 4 5 not alert at all
2. How many minutes of moderate or vigorous exercise did you get today? ________
3. Did you nap today? Yes No If yes, specify length of time: ________ (minutes)
4. How many caffeinated drinks did you have today? ___________ #of drinks
   (Note: 1 mug of coffee or cup of tea, 1 can pop = 1 drink)
5. How many alcoholic drinks did you have today? ___________ #of drinks
   (Note: 1 bottle beer or wine cooler, 1 glass of wine, 1 shot of liquor = 1 drink)
6. Did you take any medications today that you don’t regularly take every day? Yes No
   (e.g. allergy or cold medicine, pain relievers, etc.)
   If yes, record the medication name(s) and dose(s): ___________________________________

THURSDAY MORNING
UPON AWAKENING: (Please complete soon after waking up, waiting no more than 10 minutes).

7. Did you take any medication or supplement specifically to help you sleep? Yes No
   If yes, please record the medication name and dose: ______________________________
8. What time did you go to bed and begin trying to go to sleep? _____:______ a.m./p.m.
9. How long did it take you to get to sleep last night? _______ (minutes)
10. How difficult was it to get to sleep last night? (circle a number) very easy 1 2 3 4 5 very difficult
11. How many times did you wake last night (after falling asleep but before your final awakening)? ___
12. Did you wake up because of noises, lights, or some other activity? Yes No
13. If you woke up during the night, did you have difficulty getting back to sleep? Yes No
14. If you woke up during the night, during how many of these awakenings did you get out of bed? ___
15. What time did you wake up for the day and not return to sleep? _____:_____ a.m./p.m.
16. What time did you get out of bed for the day? _____:_____ a.m./p.m.

Please rate the following: (circle a number)
17. How deeply you slept last night: very deeply 1 2 3 4 5 very lightly
18. How well-rested you feel this morning: well rested 1 2 3 4 5 poorly rested
19. How alert you feel this morning: very alert 1 2 3 4 5 not alert at all
20. Overall quality of your sleep last night: very good 1 2 3 4 5 very poor
MIDUS BIOMARKER PROJECT: DAILY SLEEP DIARY

ID# ____________

THURSDAY

DATE:_____________

BEFORE BED: (Please complete the following before going to sleep).

1. How alert were you today? (circle a number): most alert 1 2 3 4 5 not alert at all
2. How many minutes of moderate or vigorous exercise did you get today? ________
3. Did you nap today? Yes No If yes, specify length of time: ________ (minutes)
4. How many caffeinated drinks did you have today? ___________ #of drinks
   (Note: 1 mug of coffee or cup of tea, 1 can pop = 1 drink)
5. How many alcoholic drinks did you have today? ___________ #of drinks
   (Note: 1 bottle beer or wine cooler, 1 glass of wine, 1 shot of liquor = 1 drink)
6. Did you take any medications today that you don’t regularly take every day? Yes No
   (e.g. allergy or cold medicine, pain relievers, etc.)
   If yes, record the medication name(s) and dose(s): _________________________________________

FRIDAY MORNING

UPON AWAKENING: (Please complete soon after waking up, waiting no more than 10 minutes).

7. Did you take any medication or supplement specifically to help you sleep? Yes No
   If yes, please record the medication name and dose: _________________________________________
8. What time did you go to bed and begin trying to go to sleep? _____:_______ a.m./p.m.
9. How long did it take you to get to sleep last night? _______ (minutes)
10. How difficult was it to get to sleep last night? (circle a number) very easy 1 2 3 4 5 very difficult
11. How many times did you wake last night (after falling asleep but before your final awakening)? ___
12. Did you wake up because of noises, lights, or some other activity? Yes No
13. If you woke up during the night, did you have difficulty getting back to sleep? Yes No
14. If you woke up during the night, during how many of these awakenings did you get out of bed? ___
15. What time did you wake up for the day and not return to sleep? _____:_____ a.m./p.m.
16. What time did you get out of bed for the day? _____:_____ a.m./p.m.

Please rate the following: (circle a number)

17. How deeply you slept last night: very deeply 1 2 3 4 5 very lightly
18. How well-rested you feel this morning: well rested 1 2 3 4 5 poorly rested
19. How alert you feel this morning: very alert 1 2 3 4 5 not alert at all
20. Overall quality of your sleep last night: very good 1 2 3 4 5 very poor
MIDUS BIOMARKER PROJECT: DAILY SLEEP DIARY

FRIDAY       DATE:_____________

BEFORE BED: (Please complete the following before going to sleep).

1. How alert were you today? (circle a number): most alert 1 2 3 4 5 not alert at all

2. How many minutes of moderate or vigorous exercise did you get today? ________

3. Did you nap today? Yes No If yes, specify length of time: _______ (minutes)

4. How many caffeinated drinks did you have today? ___________ #of drinks
   (Note: 1 mug of coffee or cup of tea, 1 can pop = 1 drink)

5. How many alcoholic drinks did you have today? ___________ #of drinks
   (Note: 1 bottle beer or wine cooler, 1 glass of wine, 1 shot of liquor = 1 drink)

6. Did you take any medications today that you don’t regularly take every day? Yes No
   (e.g. allergy or cold medicine, pain relievers, etc.)
   If yes, record the medication name(s) and dose(s): _________________________________________

SATURDAY MORNING

UPON AWAKENING: (Please complete soon after waking up, waiting no more than 10 minutes).

7. Did you take any medication or supplement specifically to help you sleep? Yes No
   If yes, please record the medication name and dose: _________________________________________

8. What time did you go to bed and begin trying to go to sleep? _____:______ a.m./p.m.

9. How long did it take you to get to sleep last night? _______ (minutes)

10. How difficult was it to get to sleep last night? (circle a number) very easy 1 2 3 4 5 very difficult

11. How many times did you wake last night (after falling asleep but before your final awakening)? ___

12. Did you wake up because of noises, lights, or some other activity? Yes No

13. If you woke up during the night, did you have difficulty getting back to sleep? Yes No

14. If you woke up during the night, during how many of these awakenings did you get out of bed? ___

15. What time did you wake up for the day and not return to sleep? _____:_____ a.m./p.m.

16. What time did you get out of bed for the day? _____:_____ a.m./p.m.

Please rate the following: (circle a number)

17. How deeply you slept last night: very deeply 1 2 3 4 5 very lightly

18. How well-rested you feel this morning: well rested 1 2 3 4 5 poorly rested

19. How alert you feel this morning: very alert 1 2 3 4 5 not alert at all

20. Overall quality of your sleep last night: very good 1 2 3 4 5 very poor
MIDUS BIOMARKER PROJECT: DAILY SLEEP DIARY
ID# ____________

SATURDAY  DATE:_____________

BEFORE BED: (Please complete the following before going to sleep).

1. How alert were you today? (circle a number): most alert 1 2 3 4 5 not alert at all
2. How many minutes of moderate or vigorous exercise did you get today? ________
3. Did you nap today? Yes No If yes, specify length of time: ________ (minutes)
4. How many caffeinated drinks did you have today? ___________ #of drinks
   (Note: 1 mug of coffee or cup of tea, 1 can pop = 1 drink)
5. How many alcoholic drinks did you have today? ____________ #of drinks
   (Note: 1 bottle beer or wine cooler, 1 glass of wine, 1 shot of liquor = 1 drink)
6. Did you take any medications today that you don’t regularly take every day? Yes No
   (e.g. allergy or cold medicine, pain relievers, etc.)
   If yes, record the medication name(s) and dose(s): __________________________________________

SUNDAY MORNING

UPON AWAKENING: (Please complete soon after waking up, waiting no more than 10 minutes).

7. Did you take any medication or supplement specifically to help you sleep? Yes No
   If yes, please record the medication name and dose: __________________________________________
8. What time did you go to bed and begin trying to go to sleep? _____:______ a.m./p.m.
9. How long did it take you to get to sleep last night? _______ (minutes)
10. How difficult was it to get to sleep last night? (circle a number) very easy 1 2 3 4 5 very difficult
11. How many times did you wake last night (after falling asleep but before your final awakening)? ___
12. Did you wake up because of noises, lights, or some other activity? Yes No
13. If you woke up during the night, did you have difficulty getting back to sleep? Yes No
14. If you woke up during the night, during how many of these awakenings did you get out of bed? ___
15. What time did you wake up for the day and not return to sleep? _____:_____ a.m./p.m.
16. What time did you get out of bed for the day? _____:_____ a.m./p.m.

Please rate the following: (circle a number)

17. How deeply you slept last night: very deeply 1 2 3 4 5 very lightly
18. How well-rested you feel this morning: well rested 1 2 3 4 5 poorly rested
19. How alert you feel this morning: very alert 1 2 3 4 5 not alert at all
20. Overall quality of your sleep last night: very good 1 2 3 4 5 very poor
MIDUS BIOMARKER PROJECT: DAILY SLEEP DIARY

ID# ____________

SUNDAY          DATE:_____________

BEFORE BED: (Please complete the following before going to sleep).

1. How alert were you today? (circle a number): most alert 1 2 3 4 5 not alert at all

2. How many minutes of moderate or vigorous exercise did you get today? ________

3. Did you nap today? Yes No If yes, specify length of time: ________ (minutes)

4. How many caffeinated drinks did you have today? ___________ #of drinks
   (Note: 1 mug of coffee or cup of tea, 1 can pop = 1 drink)

5. How many alcoholic drinks did you have today? ___________ #of drinks
   (Note: 1 bottle beer or wine cooler, 1 glass of wine, 1 shot of liquor = 1 drink)

6. Did you take any medications today that you don’t regularly take every day? Yes No
   (e.g. allergy or cold medicine, pain relievers, etc.)
   If yes, record the medication name(s) and dose(s): _________________________________________

MONDAY MORNING

UPON AWAKENING: (Please complete soon after waking up, waiting no more than 10 minutes).

7. Did you take any medication or supplement specifically to help you sleep? Yes No
   If yes, please record the medication name and dose: _________________________________________

8. What time did you go to bed and begin trying to go to sleep? _____:______ a.m./p.m.

9. How long did it take you to get to sleep last night? ________ (minutes)

10. How difficult was it to get to sleep last night? (circle a number) very easy 1 2 3 4 5 very difficult

11. How many times did you wake last night (after falling asleep but before your final awakening)? ___

12. Did you wake up because of noises, lights, or some other activity? Yes No

13. If you woke up during the night, did you have difficulty getting back to sleep? Yes No

14. If you woke up during the night, during how many of these awakenings did you get out of bed? ___

15. What time did you wake up for the day and not return to sleep? _____:_____ a.m./p.m.

16. What time did you get out of bed for the day? _____:_____ a.m./p.m.

Please rate the following: (circle a number)

17. How deeply you slept last night: very deeply 1 2 3 4 5 very lightly

18. How well-rested you feel this morning: well rested 1 2 3 4 5 poorly rested

19. How alert you feel this morning: very alert 1 2 3 4 5 not alert at all

20. Overall quality of your sleep last night: very good 1 2 3 4 5 very poor
MIDUS BIOMARKER PROJECT: DAILY SLEEP DIARY  
ID# ____________  

MONDAY    DATE:_____________  

BEFORE BED: (Please complete the following before going to sleep).

1. How alert were you today? (circle a number):  most alert  1   2   3   4   5  not alert at all  
2. How many minutes of moderate or vigorous exercise did you get today? ________  
3. Did you nap today?  Yes  No  If yes, specify length of time: _______ (minutes)  
4. How many caffeinated drinks did you have today? ___________ #of drinks  
(Note: 1 mug of coffee or cup of tea, 1 can pop = 1 drink)  
5. How many alcoholic drinks did you have today? ____________  #of drinks  
(Note: 1 bottle beer or wine cooler, 1 glass of wine, 1 shot of liquor = 1 drink)  
6. Did you take any medications today that you don’t regularly take every day?  Yes  No  
(e.g. allergy or cold medicine, pain relievers, etc.)  
If yes, record the medication name(s) and dose(s): _________________________________________  

TUESDAY MORNING  

UPON AWAKENING: (Please complete soon after waking up, waiting no more than 10 minutes).  

7. Did you take any medication or supplement specifically to help you sleep?  Yes  No  
If yes, please record the medication name and dose: ___________________________________________  
8. What time did you go to bed and begin trying to go to sleep? _____:_______ a.m./p.m.  
9. How long did it take you to get to sleep last night?  _____  (minutes)  
10. How difficult was it to get to sleep last night? (circle a number)  very easy  1   2   3   4   5  very difficult  
11. How many times did you wake last night (after falling asleep but before your final awakening)? ___  
12. Did you wake up because of noises, lights, or some other activity?  Yes  No  
13. If you woke up during the night, did you have difficulty getting back to sleep?  Yes  No  
14. If you woke up during the night, during how many of these awakenings did you get out of bed? ___  
15. What time did you wake up for the day and not return to sleep?  _____:_____ a.m./p.m.  
16. What time did you get out of bed for the day?  _____:_____ a.m./p.m.  

Please rate the following: (circle a number)  

17. How deeply you slept last night:  very deeply  1   2   3   4   5  very lightly  
18. How well-rested you feel this morning:  well rested  1   2   3   4   5  poorly rested  
19. How alert you feel this morning:  very alert  1   2   3   4   5  not alert at all  
20. Overall quality of your sleep last night:  very good  1   2   3   4   5  very poor