## Sleep Journal Workbook

Keeping a sleep journal may help you get some sleep.


## Introduction

## Obstructive sleep apnea (OSA), a sleep disorder that is very common and treatable, is a chronic condition that affects

 as many as 22 million Americans* This workbook will provide additional information and questions to help you identify if you may have OSA, as well as Sleep Journals to be filled in by you and shared with your doctor.
## Sleep Journals

Included are three Sleep Journals to be completed before bed and three Sleep Journals to be completed after waking up. Each journal page is for a P-day period. Once completed, you should share these with your doctor. The information you record could help your doctor identify if you have OSA and the best treatment for you.

## OSA Background

Many people are unaware that they may suffer from OSA, which is responsible for most cases of sleep apnea. One of the reasons that OSA is under-diagnosed is that it only happens when you are asleep and therefore, you don't know it is happening. OSA causes breathing pauses (apneas) or very shallow breathing during sleep. During apneas, your oxygen levels can fall to dangerously low levels, potentially leading to serious health conditions.

Males and females of any age can be diagnosed with OSA. Men over 40 or with a large neck circumference, post-menopausal women, and those who are overweight are at higher risk. OSA affects your sleep quality even after sleeping a full night, making you still feel sleepy in the morning, unable to feel alert, concentrate, and perform daily tasks. Poor sleep quality, combined with unhealthy oxygen levels, can negatively affect your body.

Taking the time to learn about OSA, your risk factors, and how it can affect you are the first steps towards better health. If you think you may have OSA, you should make an appointment with your doctor and fill out these Sleep Journals. For more information, call Breathe Pennsylvania at P24-772-1750 or visit breathepa.org.

[^0]
## $0+\mathrm{A}$

Q:
If I don't know that I stop breathing at night, what other symptoms may indicate I have OSA?

Your partner may complain that you snore loudly or wake up suddenly by gasping or choking. You may wake up to use the bathroom several times a night. In the morning, you may have headaches or a very dry mouth. During the day, you may feel unrefreshed, extremely tired or unable to concentrate.

OSA has been linked to many other serious health conditions including high blood pressure, an increased risk of a heart attack or stroke, or worsening heart failure. People with OSA are more likely to suffer from diabetes or be overweight than those who don't have OSA. Those who have OSA may struggle with memory issues, depression and a greater chance of being involved in a work-related or motor vehicle accident.

Please consider completing the questionnaire in this brochure and following up with your doctor. Need more information? Call Breathe Pennsylvania at P24-772-1750.

Sleep apnea can be diagnosed at home or in a sleep center. If you are ordered a test that requires you to go to a sleep center, the test is called a polysomnography. You will sleep overnight in a controlled environment where a specially trained technologist will record your breathing, heart rate, oxygen levels, body movements, brain activity and eye movements while you sleep. If you are ordered a home sleep test (HST), you will be provided equipment and directions to set up and use the equipment at home. This test typically records your breathing, heart rate and oxygen levels. A technologist will not be in your home during this study. The type of test ordered depends on your physician, your overall health condition and your insurance.

Q: | What happens after my sleep study?
Your sleep study will be reviewed and interpreted by a sleep specialist. After this is done, your results will be sent to the physician who ordered your study. You should follow-up with your physician to discuss your test results and any treatments.
@: | What if I am diagnosed with OSA?
A: There are three classifications of OSA: mild, moderate and severe. Your treatment options will depend on the results of your sleep study. In addition to other treatments, your doctor may discuss lifestyle changes with you such as diet changes, weight loss, and exercise. You may also be encouraged to change your sleeping position.

## Consequences of Untreated OSA



## WEIGHT GAIN

## STRESS ON THE HEART

- Coronary Artery Disease
- Cardiac Arrhythmias
- Heart Disease
- Congestive Heart Failure
- Sudden Death
- Hypertension

HIGHER RISK
OF DEPRESSION AND ANXIETY

##  OF DIABETES



000 000

## Sleep Journal

## Complete before Bed

Start date: $\qquad$ /__ I__

Day of the week $\quad$| Day 1 |
| :--- |

$\qquad$
$\qquad$
$\qquad$
$\qquad$
$\qquad$ Day 7

I DRANK CAFFEINATED BEVERAGES:

| Morning (How many?) |  |  |  |  |  |
| :--- | :--- | :--- | :--- | :--- | :--- | :--- |
| Afternoon (How many?) |  |  |  |  |  |
| Evening (How many?) |  |  |  |  |  |

## I EXERCISED AT LEAST 20 MINUTES IN THE:

| Morning (Circle one) | Yes / No | Yes / No | Yes / No | Yes / No | Yes / No | Yes / No | Yes / No |
| :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: |
| Afternoon (Circle one) | Yes / No | Yes / No | Yes / No | Yes / No | Yes / No | Yes / No | Yes / No |
| Evening (Circle one) | Yes/No | Yes / No | Yes / No | Yes / No | Yes / No | Yes / No | Yes / No |
| I TOOK A NAP TODAY: |  |  |  |  |  |  |  |
| Yes or No (Circle one) | Yes / No | Yes / No | Yes / No | Yes / No | Yes / No | Yes / No | Yes / No |
| Length |  |  |  |  |  |  |  |


| Not likely | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ |
| :--- | :--- | :--- | :--- | :--- | :--- | :--- | :--- |
| Somewhat likely | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ |
| Very likely | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ |

APPROXIMATELY 2-3 HOURS BEFORE BED, I DRANK/ATE:

| Alcohol | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ |
| :--- | :--- | :--- | :--- | :--- | :--- | :--- | :--- | :--- |
| Heavy meal | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ |
| Caffeine | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ |
| IN THE HOUR BEFORE GOING TO BED, MY ROUTINE INCLUDED: |  |  |  |  |  |  |  |
| Reading | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ |
| Using electronics | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ |
| Taking a bath | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ |
| Relaxing exercises | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ |
| Watching TV | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ |
| Other (Please specify) |  | $\square$ | $\square$ | $\square$ | $\square$ |  |  |

## Sleep Journal <br> Complete after Waking Up

Start date: $\qquad$ /__/__

| Day of the week | Day 1 | $\text { Day } 2$ | Day 3 | Day 4 | Day 5 | Day 6 | Day 7 |
| :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: |
| I went to bed at: | PM / AM | PM / AM | PM / AM | PM / AM | PM / AM | PM / AM | PM / AM |
| I got out of bed at: | AM / PM | AM / PM | AM / PM | AM / PM | AM / PM | AM / PM | AM / PM |
| LAST NIGHT I FELL ASLEEP: |  |  |  |  |  |  |  |
| Easily | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ |
| After some time | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ |
| With difficulty | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ |

## I WOKE UP DURING THE NIGHT:

| Number of times |  |  |  |  |  |  |  |  |
| :--- | :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: |
| I slept a total of (hours) |  |  |  |  |  |  |  |  |
| MY SLEEP WAS DISTURBED BY: |  |  |  |  |  |  |  |  |
| Noise | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ |  |
| Lights | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ |  |
| Pets | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ |  |
| Allergies | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ |  |
| Temperature | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ |  |
| Discomfort | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ |  |
| Temperature | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ |  |

WHEN I WOKE UP I FELT:

| Refreshed | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ |
| :--- | :---: | :---: | :---: | :---: | :---: | :---: | :---: |
| Somewhat refreshed | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ |
| Fatigued | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ |

## NOTES:

Record any other factors that may have affected your sleep

## Sleep Journal

## Complete before Bed

Start date: $\qquad$ /__ I__

Day of the week $\quad$| Day 1 |
| :--- |

$\qquad$
$\qquad$
$\qquad$
$\qquad$
$\qquad$ Day 7

I DRANK CAFFEINATED BEVERAGES:

| Morning (How many?) |  |  |  |  |  |
| :--- | :--- | :--- | :--- | :--- | :--- | :--- |
| Afternoon (How many?) |  |  |  |  |  |
| Evening (How many?) |  |  |  |  |  |

## I EXERCISED AT LEAST 20 MINUTES IN THE:

| Morning (Circle one) | Yes / No | Yes / No | Yes / No | Yes / No | Yes / No | Yes / No | Yes / No |
| :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: |
| Afternoon (Circle one) | Yes / No | Yes / No | Yes / No | Yes / No | Yes / No | Yes / No | Yes / No |
| Evening (Circle one) | Yes/No | Yes / No | Yes / No | Yes / No | Yes / No | Yes / No | Yes / No |
| I TOOK A NAP TODAY: |  |  |  |  |  |  |  |
| Yes or No (Circle one) | Yes / No | Yes / No | Yes / No | Yes / No | Yes / No | Yes / No | Yes / No |
| Length |  |  |  |  |  |  |  |


| Not likely | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ |
| :--- | :--- | :--- | :--- | :--- | :--- | :--- | :--- |
| Somewhat likely | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ |
| Very likely | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ |

APPROXIMATELY 2-3 HOURS BEFORE BED, I DRANK/ATE:

| Alcohol | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ |
| :--- | :--- | :--- | :--- | :--- | :--- | :--- | :--- | :--- |
| Heavy meal | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ |
| Caffeine | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ |
| IN THE HOUR BEFORE GOING TO BED, MY ROUTINE INCLUDED: |  |  |  |  |  |  |  |
| Reading | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ |
| Using electronics | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ |
| Taking a bath | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ |
| Relaxing exercises | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ |
| Watching TV | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ |
| Other (Please specify) |  | $\square$ | $\square$ | $\square$ | $\square$ |  |  |

## Sleep Journal <br> Complete after Waking Up

Start date: $\qquad$ /__/__

| Day of the week | Day 1 | $\text { Day } 2$ | Day 3 | Day 4 | Day 5 | Day 6 | Day 7 |
| :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: |
| I went to bed at: | PM / AM | PM / AM | PM / AM | PM / AM | PM / AM | PM / AM | PM / AM |
| I got out of bed at: | AM / PM | AM / PM | AM / PM | AM / PM | AM / PM | AM / PM | AM / PM |
| LAST NIGHT I FELL ASLEEP: |  |  |  |  |  |  |  |
| Easily | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ |
| After some time | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ |
| With difficulty | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ |

## I WOKE UP DURING THE NIGHT:

| Number of times |  |  |  |  |  |  |  |  |
| :--- | :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: |
| I slept a total of (hours) |  |  |  |  |  |  |  |  |
| MY SLEEP WAS DISTURBED BY: |  |  |  |  |  |  |  |  |
| Noise | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ |  |
| Lights | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ |  |
| Pets | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ |  |
| Allergies | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ |  |
| Temperature | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ |  |
| Discomfort | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ |  |
| Temperature | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ |  |

WHEN I WOKE UP I FELT:

| Refreshed | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ |
| :--- | :---: | :---: | :---: | :---: | :---: | :---: | :---: |
| Somewhat refreshed | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ |
| Fatigued | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ |

## NOTES:

Record any other factors that may have affected your sleep

## Sleep Journal

## Complete before Bed

Start date: $\qquad$ /__ I__

Day of the week $\quad$| Day 1 |
| :--- |

$\qquad$
$\qquad$
$\qquad$
$\qquad$
$\qquad$ Day 7

I DRANK CAFFEINATED BEVERAGES:

| Morning (How many?) |  |  |  |  |  |
| :--- | :--- | :--- | :--- | :--- | :--- | :--- |
| Afternoon (How many?) |  |  |  |  |  |
| Evening (How many?) |  |  |  |  |  |

## I EXERCISED AT LEAST 20 MINUTES IN THE:

| Morning (Circle one) | Yes / No | Yes / No | Yes / No | Yes / No | Yes / No | Yes / No | Yes / No |
| :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: |
| Afternoon (Circle one) | Yes / No | Yes / No | Yes / No | Yes / No | Yes / No | Yes / No | Yes / No |
| Evening (Circle one) | Yes/No | Yes / No | Yes / No | Yes / No | Yes / No | Yes / No | Yes / No |
| I TOOK A NAP TODAY: |  |  |  |  |  |  |  |
| Yes or No (Circle one) | Yes / No | Yes / No | Yes / No | Yes / No | Yes / No | Yes / No | Yes / No |
| Length |  |  |  |  |  |  |  |


| Not likely | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ |
| :--- | :--- | :--- | :--- | :--- | :--- | :--- | :--- |
| Somewhat likely | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ |
| Very likely | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ |

APPROXIMATELY 2-3 HOURS BEFORE BED, I DRANK/ATE:

| Alcohol | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ |
| :--- | :--- | :--- | :--- | :--- | :--- | :--- | :--- | :--- |
| Heavy meal | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ |
| Caffeine | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ |
| IN THE HOUR BEFORE GOING TO BED, MY ROUTINE INCLUDED: |  |  |  |  |  |  |  |
| Reading | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ |
| Using electronics | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ |
| Taking a bath | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ |
| Relaxing exercises | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ |
| Watching TV | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ |
| Other (Please specify) |  | $\square$ | $\square$ | $\square$ | $\square$ |  |  |

## Sleep Journal <br> Complete after Waking Up

Start date: $\qquad$ /__/__

| Day of the week | Day 1 | $\text { Day } 2$ | Day 3 | Day 4 | Day 5 | Day 6 | Day 7 |
| :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: |
| I went to bed at: | PM / AM | PM / AM | PM / AM | PM / AM | PM / AM | PM / AM | PM / AM |
| I got out of bed at: | AM / PM | AM / PM | AM / PM | AM / PM | AM / PM | AM / PM | AM / PM |
| LAST NIGHT I FELL ASLEEP: |  |  |  |  |  |  |  |
| Easily | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ |
| After some time | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ |
| With difficulty | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ |

## I WOKE UP DURING THE NIGHT:

| Number of times |  |  |  |  |  |  |  |  |
| :--- | :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: |
| I slept a total of (hours) |  |  |  |  |  |  |  |  |
| MY SLEEP WAS DISTURBED BY: |  |  |  |  |  |  |  |  |
| Noise | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ |  |
| Lights | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ |  |
| Pets | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ |  |
| Allergies | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ |  |
| Temperature | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ |  |
| Discomfort | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ |  |
| Temperature | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ |  |

WHEN I WOKE UP I FELT:

| Refreshed | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ |
| :--- | :---: | :---: | :---: | :---: | :---: | :---: | :---: |
| Somewhat refreshed | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ |
| Fatigued | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ | $\square$ |

## NOTES:

Record any other factors that may have affected your sleep

## STOP-BANG Questionnaire*

The STOP-BANG questionnaire is commonly used by healthcare providers as a screening tool for obstructive sleep apnea. It is included here as only a tool to help you begin a conversation with your doctor about your risk of OSA.

| STOP |  |  |
| :---: | :---: | :---: |
| S (snore) | Do you snore loudly (louder than talking or loud enough to be heard through closed doors)? | Yes/No |
| T (tired) | Do you often feel tired, fatigued, or sleepy during daytime? | Yes/No |
| O (observed) | Has anyone observed you stop breathing during sleep? | Yes/No |
| P (blood pressure) | Do you have or are you being treated for high blood pressure? | Yes/No |
| BANG |  |  |
| B (body mass index [BMI]) | BMI $>35 \mathrm{~kg} / \mathrm{m}^{2}$ ? | Yes/No |
| A (age) | Age > 50 years? | Yes/No |
| N (neck) | Neck circumference > 40 cm ? | Yes/No |
| G (gender) | Gender male? | Yes/No |
| Yes to $\geq 3$ questions $=$ high risk of obstructive sleep apnea <br> Yes to $<3$ questions = low risk of obstructive sleep apnea |  |  |

[^1]
## Sleep Partner Questionnaire

Sleep Partner Name: $\qquad$ Dates: $\qquad$
Your Name: $\qquad$
I have observed my sleep partner's sleep patterns: $\square$ Never $\square$ Once or Twice $\square$ Often $\square$ Every night
I HAVE OBSERVED THE FOLLOWING BEHAVIORS WHILE MY SLEEP PARTNER IS ASLEEP: (check all that apply)
$\square$ Snoring $\square$ Light $\square$ Moderate $\square$ Loud What makes it worse? (check all that apply) $\square$ Sleeping on back $\square$ Sleeping on side $\square$ Fatigue $\square$ Alcohol
$\square$ Occasional loud snorting
$\square$ Choking
$\square$ Pauses in breathing
$\square$ Talking in sleep
$\square$ Wetting bed
$\square$ Waking with pain
$\square$ Getting out of bed when not awake
$\square$ Becoming very rigid and shaking
$\square$ Twisting or kicking legs
$\square$ Trouble staying awake
Grinding teeth
Sitting up in bed when not awake
Head rocking or banging
$\square$ Biting tongue

- Crying out

Other
$\qquad$

PLEASE DESCRIBE THE BEHAVIORS CHECKED ABOVE IN MORE DETAIL; INCLUDE THE TIME WHEN IT OCCURS AND HOW OFTEN IT OCCURS:

## HAS YOUR SLEEP PARTNER FALLEN ASLEEP DURING NORMAL ACTIVITIES OR IN DANGEROUS SITUATIONS?

$\square$ Yes $\square$ No If yes, please explain:


Learn more at:
www.breathepa.org
www.sleepapnea.org
www.sleepassociation.org
www.sleepfoundation.org



[^0]:    *sleepapnea.org

[^1]:    *Adapted from Chung et al.

