

Snoring & Sleep Journal

Start Date: _____

End Date: _____

Use this journal to track sleep quality, snoring patterns, and lifestyle factors that may affect your snoring. The more consistent you are, the easier it is to identify triggers and improvements.

 **Tip:** At the end of the week, review your logs to see patterns. Are certain foods, positions, or habits making it worse?

[Grab the Snore Reduction Checklist here...](#)

[Breathing Exercises for you to try](#)

Say Goodbye to Snoring

[Available here](#)

A Natural Solution for Quiet Nights and Vibrant Mornings - My Proven Formula for Sound Sleep and Lasting Vitality.

-  *Tired of restless nights and daytime fatigue?*
-  *Struggling with snoring that disrupts sleep and strains relationships?*
-  *Wondering how to stop snoring naturally without costly devices or surgery?*

This book is your go-to guide for transforming restless nights into deep, rejuvenating sleep. Whether you're looking for simple lifestyle changes, dietary tweaks, or practical techniques to open your airways naturally, *Say Goodbye to Snoring* offers an effective, non-invasive approach to eliminating snoring and improving sleep health.





Daily Log Template (Day 1)

Date: _____

Bedtime: _____

Wake-up Time: _____

Estimated Hours of Sleep: _____

Snoring (Circle One):

☐ None ☐ Mild ☐ Moderate ☐ Loud

Snoring Duration:

☐ Not sure ☐ <1 hour ☐ 1–3 hours ☐ 3+ hours

Sleep Position:

☐ Back ☐ Side ☐ Stomach ☐ Multiple

Used any aids?

(e.g., nasal strips, humidifier, mouthguard)

☐ Yes ☐ No – What?: _____

Consumed alcohol or heavy meal before bed?

☐ Yes ☐ No – Time: _____

Notes or partner observations:



Daily Log Template (Day 2)

Date: _____

Bedtime: _____

Wake-up Time: _____

Estimated Hours of Sleep: _____

Snoring (Circle One):

☐ None ☐ Mild ☐ Moderate ☐ Loud

Snoring Duration:

☐ Not sure ☐ <1 hour ☐ 1–3 hours ☐ 3+ hours

Sleep Position:

☐ Back ☐ Side ☐ Stomach ☐ Multiple

Used any aids?

(e.g., nasal strips, humidifier, mouthguard)

☐ Yes ☐ No – What?: _____

Consumed alcohol or heavy meal before bed?

☐ Yes ☐ No – Time: _____

Notes or partner observations:



Daily Log Template (Day 3)

Date: _____

Bedtime: _____

Wake-up Time: _____

Estimated Hours of Sleep: _____

Snoring (Circle One):

☐ None ☐ Mild ☐ Moderate ☐ Loud

Snoring Duration:

☐ Not sure ☐ <1 hour ☐ 1–3 hours ☐ 3+ hours

Sleep Position:

☐ Back ☐ Side ☐ Stomach ☐ Multiple

Used any aids?

(e.g., nasal strips, humidifier, mouthguard)

☐ Yes ☐ No – What?: _____

Consumed alcohol or heavy meal before bed?

☐ Yes ☐ No – Time: _____

Notes or partner observations:



Daily Log Template (Day 4)

Date: _____

Bedtime: _____

Wake-up Time: _____

Estimated Hours of Sleep: _____

Snoring (Circle One):

☐ None ☐ Mild ☐ Moderate ☐ Loud

Snoring Duration:

☐ Not sure ☐ <1 hour ☐ 1–3 hours ☐ 3+ hours

Sleep Position:

☐ Back ☐ Side ☐ Stomach ☐ Multiple

Used any aids?

(e.g., nasal strips, humidifier, mouthguard)

☐ Yes ☐ No – What?: _____

Consumed alcohol or heavy meal before bed?

☐ Yes ☐ No – Time: _____

Notes or partner observations:



Daily Log Template (Day 5)

Date: _____

Bedtime: _____

Wake-up Time: _____

Estimated Hours of Sleep: _____

Snoring (Circle One):

☐ None ☐ Mild ☐ Moderate ☐ Loud

Snoring Duration:

☐ Not sure ☐ <1 hour ☐ 1–3 hours ☐ 3+ hours

Sleep Position:

☐ Back ☐ Side ☐ Stomach ☐ Multiple

Used any aids?

(e.g., nasal strips, humidifier, mouthguard)

☐ Yes ☐ No – What?: _____

Consumed alcohol or heavy meal before bed?

☐ Yes ☐ No – Time: _____

Notes or partner observations:



Daily Log Template (Day 6)

Date: _____

Bedtime: _____

Wake-up Time: _____

Estimated Hours of Sleep: _____

Snoring (Circle One):

☐ None ☐ Mild ☐ Moderate ☐ Loud

Snoring Duration:

☐ Not sure ☐ <1 hour ☐ 1–3 hours ☐ 3+ hours

Sleep Position:

☐ Back ☐ Side ☐ Stomach ☐ Multiple

Used any aids?

(e.g., nasal strips, humidifier, mouthguard)

☐ Yes ☐ No – What?: _____

Consumed alcohol or heavy meal before bed?

☐ Yes ☐ No – Time: _____

Notes or partner observations:



Daily Log Template (Day 7)

Date: _____

Bedtime: _____

Wake-up Time: _____

Estimated Hours of Sleep: _____

Snoring (Circle One):

☐ None ☐ Mild ☐ Moderate ☐ Loud

Snoring Duration:

☐ Not sure ☐ <1 hour ☐ 1–3 hours ☐ 3+ hours

Sleep Position:

☐ Back ☐ Side ☐ Stomach ☐ Multiple

Used any aids?

(e.g., nasal strips, humidifier, mouthguard)

☐ Yes ☐ No – What?: _____

Consumed alcohol or heavy meal before bed?

☐ Yes ☐ No – Time: _____

Notes or partner observations:
