Sleep History Form

FORM CODE: SLE
VERSION A 1/29/2009

PARTICIPANT ID NUMBER: | | | | | | | | CONTACT YEAR: | 0 | 9 |

LAST NAME: | | | | | | | | | | | | | INITIALS: | | |

INSTRUCTIONS: This form should be completed during the participant's clinic visit. ID Number, Contact Year, and Name must be entered above. Whenever numerical responses are required, enter the number so that the last digit appears in the rightmost box. Enter leading zeroes where necessary to fill all boxes. If a paper form is used and a number is entered incorrectly, mark through the incorrect entry with an "X". Code the correct entry clearly above the incorrect entry. For "multiple choice" and "yes/no" type questions, circle the letter corresponding to the most appropriate response. If a letter is circled incorrectly, mark through it with an "X" and circle the correct response.

A. SLEEP

The following questions are about your sleep. Please consider both what others have told you about your sleep and what you know yourself.

1. How much sleep do you usually get at night (or your main sleep period) on weekdays or workdays? | | | hours

2. How long does it usually take you to fall asleep at bedtime? | | | hours **(1 = 1 hour or less)**

3. In the past 12 months, how often do you snore while you are sleeping?
[Don't know = 7, Refused = 8, Missing = 9].....

Never	1
Rarely (1 to 2 nights a week)	2
Occasionally (3-4 nights a week)	3
Frequently (5 or more nights a week)	4

4. In the past 12 months, how often do you snort, gasp, or stop breathing while you are asleep? (select one answer)
[Don't know = 7, Refused = 8, Missing = 9].....

Never	1
Rarely (1 to 2 nights a week)	2
Occasionally (3-4 nights a week)	3
Frequently (5 or more nights a week)	4

5. Please indicate how often in the past month you experienced each of the following. (mark one answer for each item)

		NEVER *(0)*	RARELY *(Once per month or less)*	SOMETIMES *(2-4 times per month)*	OFTEN *(5-15 times per month)*	ALMOST ALWAYS *(16-30 times per month)*	DON'T KNOW	REFUSED	MISSING
5a.	Have trouble falling asleep	1	2	3	4	5	7	8	9
5b.	Wake up during the night and have difficulty getting back to sleep.....	1	2	3	4	5	7	8	9
5c.	Wake up in the morning and be unable to get back to sleep.	1	2	3	4	5	7	8	9
5d.	Feel excessively (overly) sleepy during the day.	1	2	3	4	5	7	8	9

6. During the past month, how would you rate your sleep quality overall?
[Don't know = 7, Refused = 8, Missing = 9].....

Excellent	1
Very good	2
Good	3
Fair	4
Poor	5

7. What is the chance that you would doze off or fall asleep (not just "feel tired") in each of the following situations? (Select one answer for each situation. If you are never or rarely in the situation, please give your best guess for what would happen.)

		NO CHANCE	SLIGHT CHANCE	MODERATE CHANCE	HIGH CHANCE	DON'T KNOW	REFUSED	MISSING
7a.	Sitting and reading.....	1	2	3	4	7	8	9
7b.	Watching TV.....	1	2	3	4	7	8	9
7c.	Sitting inactive in a public place (such as a theater or a meeting)	1	2	3	4	7	8	9
7d.	Riding as a passenger in a car for an hour without a break.....	1	2	3	4	7	8	9
7e.	Lying down to rest in the afternoon when circumstances permit.....	1	2	3	4	7	8	9
7f.	Sitting and talking to someone.....	1	2	3	4	7	8	9
7g.	Sitting quietly after lunch without alcohol.....	1	2	3	4	7	8	9
7h.	In a car, while stopped for a few minutes in traffic.....	1	2	3	4	7	8	9
7i.	At the dinner table	1	2	3	4	7	8	9
7j.	While driving.....	1	2	3	4	7	8	9

8. Have you ever been told by a doctor or other health professional that you have any of the following (Select one response for each item)

	YES	NO	DON'T KNOW	REFUSED	MISSING
8a. Sleep apnea or obstructive sleep apnea	1	2	7	8	9
8b. Insomnia.....	1	2	7	8	9
8c. Restless legs	1	2	7	8	9

B. ADMINISTRATIVE INFORMATION

9. Method of data collection: ..... Computer 1

Paper form 2

10. Data Collected. .....In house 1

Offsite 2

11. Date of data collection: ..... | | | / | | | / | | | | |
m m d d y y y y

12. Code number of person completing this form: ..... | | | |