



SLEEP HEART HEALTH STUDY

SLEEP HABITS QUESTIONNAIRE

ID#: PPTID

Field Center: 3 1 SITE02

Today's date: DATE02
month day year

Please complete as thoroughly as possible and to the best of your knowledge.

1 A. At what time do you usually FALL ASLEEP on weekdays or your work days?

TFAWDH02 : TFAWDM02
1 A.M. (Midnight is 12:00 A.M.)
2 P.M. TFAWDA02

B. At what time do you usually FALL ASLEEP on weekends or your non-work days?

TFAWEH02 : TFAWEM02
1 A.M. (Midnight is 12:00 A.M.)
2 P.M. TFAWEA02

2 How many minutes does it usually take you to fall asleep at bedtime?

MI2SLP02 (Number of minutes)

3 A. At what time do you usually WAKE UP on weekdays or your work days?

TWUWDH02 : TWUWDM02
1 A.M.
2 P.M. TWUWDA02

B. At what time do you usually WAKE UP on weekends or your non-work days?

TWUWEH02 : TWUWEM02
1 A.M.
2 P.M. TWUWEA02

4 How many hours of sleep do you usually get at night (or your main sleep period) on weekdays or workdays?

HRSWD02 (Number of hours)

5 How many hours of sleep do you usually get at night (or your main sleep period) on weekends or your non-work days?

HRSWE02 (Number of hours)

6 During a usual week, how many times do you nap for 5 minutes or more? (Write in "0" if you do not take any naps.)

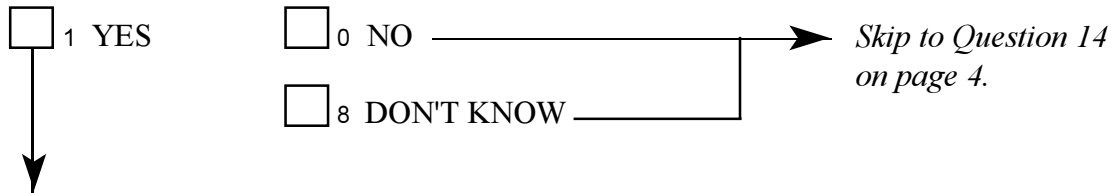
NAPS02 (Number of times)

7 Please indicate how often you experience each of the following. (Check one box for each item.)

	NEVER (0)	RARELY (1/month or less)	SOMETIMES (2-4/month)	OFTEN (5-15/month)	ALMOST ALWAYS (16-30/month)
TFA02 A. Have trouble falling asleep.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
WUDNRS02 Wake up during the night and have difficulty getting back to sleep.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
WU2EM02 Wake up too early in the morning and be unable to get back to sleep.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
FUNRES02 Feel unrested during the day, no matter how many hours of sleep you had.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
SLEEPY02 Feel excessively (overly) sleepy during the day.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
NGES02 Do not get enough sleep.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
TKPILL02 Take sleeping pills or other medication to help you sleep.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

Questions 8 through 16 are about snoring and breathing during sleep. To answer these questions, please consider both what others have told you AND what you know about yourself.

8 Have you ever snored (now or at any time in the past)? **HVSNRD02**

- 1 YES
 0 NO
 8 DON'T KNOW
- Skip to Question 14 on page 4.
- 

9 How often do you snore now? (Check one.) **HOSNR02**

- 0 Do not snore any more. —————→ Skip to Question 13 on page 4.
 1 Rarely - less than one night a week.
 2 Sometimes - 1 or 2 nights a week.
 3 Frequently - 3 to 5 nights a week.
 4 Always or almost always - 6 or 7 nights a week.
 8 Don't know.

10 How loud is your snoring? (Check one.) **LOUDSN02**

- 1 Only slightly louder than heavy breathing.
 2 About as loud as mumbling or talking.
 3 Louder than talking.
 4 Extremely loud - can be heard through a closed door.
 8 Don't know.

11 For how many years have you been snoring?

YRSSNR02 (Number of years) OR Don't know 88

12 Is your snoring: (Check one.) **ISSNOR02**

1 Increasing over time?

2 Decreasing over time?

3 Staying the same?

8 Don't know.

13 Have you ever had surgery as treatment for your snoring? **SURGTR02**

1 YES

0 NO

14 Are there times when you stop breathing during your sleep? **STPBRT02**

1 YES

0 NO

8 DON'T KNOW

→ *Skip to Question 16
on page 5.*

15 How often do you have times when you stop breathing during your sleep? **HOSTBR02**

1 Rarely - less than one night a week.

2 Sometimes - 1 or 2 nights a week.

3 Frequently - 3 to 5 nights a week.

4 Always or almost always - 6 or 7 nights a week.

8 Don't know.

16 A. Have you ever been told by a doctor that you had sleep apnea (a condition in which breathing stops briefly during sleep)? **MDSA02**

1 YES

0 NO

8 DON'T KNOW

→ Skip to Question 17 below.

B. Do you sleep with either a pressure mask ("CPAP") or a mouthpiece as treatment for your sleep apnea? **CPAP02**

1 YES

0 NO

C. Have you had surgery as treatment for your sleep apnea? **SURGSA02**

1 YES

0 NO

17 Do you usually use oxygen therapy (oxygen delivered by a mask or nasal cannula) during your sleep? **O2THPY02**

1 YES

0 NO

18 In the past year, how often, on average, have you been awakened with the following?

	NEVER (0)	RARELY (1/month or less)	SOMETIMES (2-4/month)	OFTEN (5-15/month)	ALMOST ALWAYS (16-30/month)
COUGH02 Coughing or wheezing.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
CP02 B. Chest pain or tightness.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
SOB02 C. Shortness of breath.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
SWEATS02 Sweats or hot flashes.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
NOISE02 Noise in your surroundings.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
PAINJT02 Pain in your joints, muscles, or back.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
HB02 G. Heartburn or indigestion.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
LEGCRP02 Leg cramps or leg jerks.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
NEEDBR02 Need to go to the bathroom.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

19 During the past year, how often have one or more members of your household been in or near the room where you have slept? MEMBHH02

1 NEVER 2 SOMETIMES 3 USUALLY

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

		NO CHANCE	SLIGHT CHANCE	MODERATE CHANCE	HIGH CHANCE
SITRD02	A. Sitting and reading.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
WATV02	B. Watching TV.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
SITPUB02	Sitting inactive in a public place (such as a theater or a meeting).	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
PGRCAR02	Riding as a passenger in a car for an hour without a break.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
LYDWN02	E. Lying down to rest in the afternoon when circumstances permit.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
SITTLK02	F. Sitting and talking to someone.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
SITLCH02	G. Sitting quietly after a lunch without alcohol.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
INCAR02	H. In a car, while stopped for a few minutes in traffic.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
ATTABL02	At the dinner table.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
DRIVE02	J. While driving.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4

21 About one in four ARIC participants in Minnesota will have a sleep study in his/her home. Would you be interested in undergoing a one-night sleep study (if offered)?

1 YES 2 NO 8 UNSURE

**Please return this questionnaire in the enclosed postage-paid envelope.
Thank you for your participation in the Sleep Heart Health Study!**

Field Center Use Only

0 Self administered WHOADM02 er administered, in:

- 1 English 4 Pima
 2 Spanish 5 Other, specify: _____
 3 Lakota 6 Unknown

Interviewer or Reviewer _____ Date: INTDT02 _____
month day year