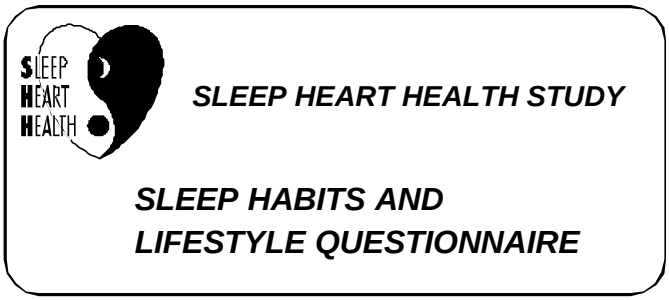

SLEEP HEART HEALTH STUDY

SLEEP HABITS AND LIFESTYLE QUESTIONNAIRE

Instructions

Thank you for taking time to fill out the enclosed Sleep Habits Questionnaire. Please fill out the form completely. You may use either pen or pencil. If you have any questions or problems while filling out the form, please call _____ at _____.

When answering a question, put a check (✓) in the box in front of the correct answer. Ignore the little numbers by the boxes. They are there to help us enter the information on the form into the computer.

If you make a mistake, put an "X" over the checkmark. Then put a checkmark in the correct box and draw a circle around that box.

If the question provides space to write an answer, write your response in that space. If necessary, continue your answer on a separate sheet of paper.

Below are examples of how to mark an answer, and how to change an answer if you make a mistake. Depending on your answer to some of the questions, you may be asked to skip other questions or parts of questions. When this occurs, instructions will be printed in *italics*, indicating which questions to go to next.

Again, thank you for your time.

1. Have you ever snored (now or at any time in the past)?

☐ 1 Yes ☑ 0 No ☐ 8 Don't know

If you wish to change an answer (in this example, change a "NO" answer to a "YES" answer):

1. Have you ever snored (now or at any time in the past)?

☑ 1 Yes ☒ 0 No ☐ 8 Don't know

Keyed: ( )

FIELD SITE USE ONLY

SLEEP HEART HEALTH STUDY

SLEEP HABITS AND LIFESTYLE QUESTIONNAIRE

Field Site ID: CLINIC
Participant ID#: PPTID
Alpha Code: SHHS
Date form initiated: FORMDATE (month / day / year)
Visit ID Code: F02 VISIT
Form & revision: SH3 FORMREV

Instructions: Our staff members will collect this questionnaire when they come to your home. If you do NOT have a home visit planned, please fill out the questionnaire and mail it back to us in the enclosed postage-paid envelope.

Please contact _____ at _____ if you have any questions.

A. Sleep

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

sh301h *(hours)* sh301m *(minutes)*

2. How much sleep do you usually get at night (or in your main sleep period) on weekends or your non-work days?

sh302h *(hours)* sh302m *(minutes)*

3. How long does it usually take you to fall asleep at bedtime?

sh303h *(hours)* sh303m *(minutes)*

4. During a usual week, how many times do you nap for 5 minutes or more?

sh304

☐ 0 None → ***Skip to item 8.***

☐ 1 1 or more times

a. Number of times during a usual week that you nap for 5 minutes or more:

sh304a _____ *(number of times)*

5. Do you try to "make time" in your schedule for a regular nap or "siesta" in the afternoon? *(check one)* sh305

☐ 0 Never or rarely. → ***Skip to item 8.***

☐ 1 Sometimes.

☐ 2 Often.

☐ 3 Everyday or almost everyday.

6. When you do nap in the afternoon, how long do you sleep?

sh306h _____ *(hours)* sh306m _____ *(minutes)*

sh306s

sh306t _____

comments

7. What are your reasons for regular napping in the afternoon? *(check all that apply)*

sh307a **a.** ☐ 1 I do not get enough sleep at night.

sh307b **b.** ☐ 1 I nap due to an illness or for medical reasons.

sh307c **c.** ☐ 1 I nap because it makes me feel refreshed in general.

sh307d **d.** ☐ 1 Other *(please explain).*

sh307ds _____

please explain

8. Please indicate how often you experience each of the following.
(check one box for each in items a through j)

		NEVER (0)	RARELY (1x/month or less)	SOMETIMES (2-4x/ month)	OFTEN (5-15x/ month)	ALMOST ALWAYS (16-30x/ month)
sh308a	**a.** Have trouble falling asleep.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
sh308b	**b.** Wake up during the night and have difficulty getting back to sleep.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
sh308c	**c.** Wake up too early in the morning and be unable to get back to sleep.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
sh308d	**d.** Feel unrested during the day, no matter how many hours of sleep you had.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
sh308e	**e.** Feel excessively (overly) sleepy during the day.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
sh308f	**f.** Do not get enough sleep.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
sh308g	**g.** Take sleeping pills or other medication to help you sleep.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
sh308h	**h.** Nasal stuffiness, obstruction or discharge at night.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
sh308i	**i.** Leg jerks.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
sh308j	**j.** Leg cramps.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

B. Snoring and breathing

Questions 9 through 15 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.

9. Have you ever snored (now or at any time in the past)? sh309

☐ 1 Yes

☐ 0 No → ***Skip to item 14.***

☐ 8 Don't know → ***Skip to item 14.***

10. How often do you snore now? *(check one)* sh310

☐ 0 Do not snore any more. → ***Skip to item 13.***

☐ 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.

11. How loud is your snoring? *(check one)* sh311

☐ 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.

12. Has your snoring been: *(check one)* sh312

☐ 1 Increasing over time?

☐ 2 Decreasing over time?

☐ 3 Staying the same?

☐ 8 Don't know.

13. Have you ever had somnoplasty, laser treatment, or surgery as treatment for your snoring? sh313

☐ 1 Yes ☐ 0 No

14. Are there times when you stop breathing during your sleep? sh314

☐ 1 Yes ☐ 0 No → ***Skip to item 16.***

☐ 8 Don't know →

15. How often do you have times when you stop breathing during your sleep? sh315

☐ 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. During the past year, how often have one or more members of your household been in or near the room where you have slept? sh316

☐ 1 Never ☐ 2 Sometimes ☐ 3 Usually

17. Have you ever been told by a doctor that you have a sleep disorder (other than sleep apnea)? sh317

☐ 1 Yes ☐ 0 No → ***Skip to item 19.***

18. What other sleep disorder? *(check all that apply)*

sh318a **a.** ☐ 1 Insomnia

sh318b **b.** ☐ 1 Restless legs

sh318c **c.** ☐ 1 Narcolepsy

sh318d **d.** ☐ 1 Other: sh318ds _____
please specify

C. Sleepiness

19. 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 <u>best guess</u> for what would happen.)*

		NO CHANCE	SLIGHT CHANCE	MODERATE CHANCE	HIGH CHANCE
sh319a	**a.** Sitting and reading.	☐ 1	☐ 2	☐ 3	☐ 4
sh319b	**b.** Watching TV.	☐ 1	☐ 2	☐ 3	☐ 4
sh319c	**c.** Sitting inactive in a public place (such as a theater or a meeting).	☐ 1	☐ 2	☐ 3	☐ 4
sh319d	**d.** Riding as a passenger in a car for an hour without a break.	☐ 1	☐ 2	☐ 3	☐ 4
sh319e	**e.** Lying down to rest in the afternoon when circumstances permit.	☐ 1	☐ 2	☐ 3	☐ 4
sh319f	**f.** Sitting and talking to someone.	☐ 1	☐ 2	☐ 3	☐ 4
sh319g	**g.** Sitting quietly after a lunch without alcohol.	☐ 1	☐ 2	☐ 3	☐ 4
sh319h	**h.** In a car, while stopped for a few minutes in traffic.	☐ 1	☐ 2	☐ 3	☐ 4
sh319i	**i.** At the dinner table.	☐ 1	☐ 2	☐ 3	☐ 4
sh319j	**j.** While driving.	☐ 1	☐ 2	☐ 3	☐ 4

D. Smoking

20. Have you smoked as many as 20 packs of cigarettes in your whole lifetime? sh320

Yes ☐ 1 No ☐ 0 → ***Skip to item 25.***

21. How many years ago did you START smoking?

sh321 _____ years

22. Since you began smoking, was there ever a period of one year or more that you did NOT smoke? sh322

Yes ☐ 1 No ☐ 0 → ***Skip to item 23.***

22a. If "Yes" how many years did you NOT Smoke?

sh322a _____ years

23. Are you currently still smoking? sh323

Yes ☐ 1 → ***Skip to item 24.*** No ☐ 0

23a. If "No" how many years ago did you STOP smoking?

sh323a _____ years

24. On average, during the entire time you smoked, how many cigarettes did you usually smoke per day?

sh324 _____ (number of cigarettes)

E. Beverages *(for questions 25-30, write "0" if you do not drink any of that beverage)*

25. On a typical day, how many cups of regular coffee (with caffeine) do you drink?

sh325 _____ cups

26. How many cups of regular tea (with caffeine) do you drink on a typical day?

sh326 _____ cups

27. How many glasses or cans of cola or other soda with caffeine do you drink on a typical day?

sh327a _____ glasses sh327b _____ cans

28. How many glasses (4 oz.) of wine do you usually have per week?

sh328 _____ glasses

29. How many bottles or cans of beer (12 oz.) do you usually have per week?

sh329 _____ cans/bottles

30. How many drinks with hard liquor (1 shot) do you usually have per week?

sh330 _____ drinks

31. Today's date: sh331 __ __ – __ __ – 2 0 __ __
month day year

Thank you for your continuing participation in the Sleep Heart Health Study!

F. Administrative information

Field Site Use Only

32. ☐ 0 Self administered/Interviewer administered, in: sh332

☐ 1 English ☐ 4 Pima

☐ 2 Spanish ☐ 5 Other, specify: sh332s _____

☐ 3 Lakota ☐ 6 Unknown

33. Interviewer or Reviewer: sh333 _____ _____

34. Date: sh334 __ __ – 2 0 0 __

month day year

35. Comments:

sh335s

sh335t

sh335u