

Multi-Ethnic Study of Atherosclerosis

Exam 4



Sleep History
Self-Administered

Participant Id#:

Acrostic:

Date: **SLEEPDT4** /
 Month Day Year

The following questions are about your sleep. Please consider both what others have told you about your sleep and what you know yourself. If you have any questions, please ask a MESA staff member.

SLPWKHR4

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

FALSLHR4

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

OFTSNR4

3. In the past 12 months, how often do you snore while you are sleeping? (select one answer)

- Never
- Rarely (1 to 2 nights a week)
- Occasionally (3-4 nights a week)
- Frequently (5 or more nights a week)
- Don't know

OFTSNRT4

4. In the past 12 months, how often do you snort, gasp, or stop breathing while you are asleep? (select one answer)

- Never
- Rarely (1 to 2 nights a week)
- Occasionally (3-4 nights a week)
- Frequently (5 or more nights a week)
- Don't know

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

TRBLSLP4

a. Have trouble falling asleep

WKNIGHT4

b. Wake up during the night and have difficulty getting back to sleep

WKEARLY4

c. Wake up too early in the morning and be unable to get back to sleep

SLPYDAY4

d. Feel excessively (overly) sleepy during the day.

	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)
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<input type="radio"/>				
<input type="radio"/>				
<input type="radio"/>				
<input type="radio"/>				

6. 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
DZREAD4 a. Sitting and reading	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
DZTV4 b. Watching TV	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
DZPUBPL4 c. Sitting inactive in a public place (such as a theater or a meeting)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
DZRDCAR4 d. Riding as a passenger in a car for an hour without a break	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
DZREST4 e. Lying down to rest in the afternoon when circumstances permit	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
DZTALK4 f. Sitting and talking to someone	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
DZLNCH4 g. Sitting quietly after lunch without alcohol	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
DZCARST4 h. In a car, while stopped for a few minutes in traffic	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
DZDINN4 i. At the dinner table	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
DZDRIVE4 j. While driving	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

7. 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)

	NO	YES	DON'T KNOW
APNEA4 a. Sleep apnea or obstructive sleep apnea	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
INSOMN4 b. Insomnia	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
RSTLEG4 c. Restless legs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

For MESA Field Center Use Only:	SLPADM4	Completed by: <input type="radio"/> Self-Administered <input type="radio"/> Interviewer-Administered	
	Interviewer ID: SLPTID4	Reviewer ID: SLPRID4	Data Entry ID: SLPDID4
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