



SLEEP HEART HEALTH STUDY

MORNING SURVEY

ID#: PPTID

Field Center: SITE10

Today's date: DATE10
month day year

After you get up, please fill out this form as completely as you can. If you have any questions, the technician will be happy to help you when your monitor is collected.

1 What time did you go to sleep last night?

TSLH10 : TSLM10
1 A.M. (Midnight is 12:00 A.M.)
TSLA10
2 P.M.

TWUH10 : TWUM10
1 A.M.
TWUA10
2 P.M.

3 How long did you sleep last night?

HWLGHR10 HOURS HWLGMM10 MINUTES

4 Please rate the quality of your sleep last night by circling a number from 1 to 5 on each of the scales below.

My sleep last night was:

A. Light LTDP10 Deep
1 2 3 4 5

B. Short SHLG10 Long
1 2 3 4 5

C. Restless REST10 Restful
1 2 3 4 5

5 Compared to your usual night's sleep, how well did you sleep last night? (Check one) **HWWELL10**

- 1 Much worse than usual
- 2 Somewhat worse than usual
- 3 As well as usual
- 4 A little better than usual
- 5 Much better than usual

6 Did you have difficulty falling asleep last night? (Check one) **DIFFA10**

- YES 1 NO 0

7 How many minutes did it take for you to fall asleep at bedtime last night?

 MINFA10 MINUTES

8 Did you take any medications last night that you didn't tell us about yesterday? **MEDS10**
(Check one)

- 1 YES (Please list them below.) 0 NO → Skip to Question 9 on page 3.
- 2 UNSURE (If you are unsure that you told us about a medication, please list it below.)

Medication Name

Strength (mg)

Print the first 20 letters only--please print clearly.

1	<input type="text"/>	<input type="text"/>
2	<input type="text"/>	<input type="text"/>
3	<input type="text"/>	<input type="text"/>
4	<input type="text"/>	<input type="text"/>
5	<input type="text"/>	<input type="text"/>

(Please continue on the back of this survey if you need additional space.)

For Questions 9 - 11, please think back to the four-hour period before you went to sleep last night.

9 How much beer, wine, or liquor (if any) did you have during the 4 hours before you went to sleep last night? (Please write "0" if you did not drink any of that beverage.)

WINE10 glasses of wine SHOTS10 mixed drinks or shots of liquor BEER10 bottles or cans of beer

10 How many of the following drinks with caffeine (if any) did you have during the 4 hours before you went to sleep last night? (Please write "0" if you did not drink any of that beverage.)

COFFEE10 cups of regular coffee (with caffeine) TEA10 cups of tea with caffeine
SODA10 glasses or cans of cola or other soda with caffeine

11 How much did you smoke (if at all) during the 4 hours before you went to sleep last night?

CGRTTS10 number of cigarettes PIPE10 number of pipe bowls CIGARS10 number of cigars

12 How much discomfort, if any, did the following parts of the monitor cause you?

		NONE	VERY LITTLE	MODERATE	A GREAT DEAL
WRHEAD10	The wires on your head	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
WRFACE10	The wires on your face	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
PLSTC10	The plastic piece over your lip	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
BELT10	The belts around your chest and stomach	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
VEST10	The vest	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
FINGER10	The finger piece	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4

13 At what time did you finish filling out this survey?

FINH10: FINM10 FINA10
 1 A.M.
 2 P.M.

Field Center Use Only

0 Self administered, WHOADM10 interviewer administered, in:

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

Interviewer or Reviewer INTID10 Date: RDATE10
month day year