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?

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

   _____ _____ : _____ _____

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?

   1. A.M.
   2. P.M.

   _____ _____ : _____ _____

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

   1. A.M.
   2. P.M.

   _____ _____ : _____ _____
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.

WUDNRS02 Wake up during the night and have difficulty getting back to sleep.

WU2EM02 Wake up too early in the morning and be unable to get back to sleep.

FUNRES02 Feel unrested during the day, no matter how many hours of sleep you had.

SLEEPY02 Feel excessively (overly) sleepy during the day.

NGES02 Do not get enough sleep.

TKPILL02 Take sleeping pills or other medication to help you sleep.
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)?

☐ 1 YES ☐ 0 NO ☐ 8 DON'T KNOW

Skip to Question 14 on page 4.

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

☐ 0 Do not snore any more.
☐ 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.

Skip to Question 13 on page 4.

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

☐ 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?

☐ 8YRSSNR02 (Number of years) ☐ 88 Don't know
12 Is your snoring: (Check one.)

☐ 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?

☐ 1 YES  ☐ 0 NO

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

☐ 1 YES  ☐ 0 NO  ☐ 8 DON'T KNOW

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

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

- [ ] 1 YES
- [ ] 0 NO
- [ ] 8 DON'T KNOW

Skip to Question 17 below.

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

- [ ] 1 YES
- [ ] 0 NO

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

<table>
<thead>
<tr>
<th>Condition</th>
<th>NEVER (0)</th>
<th>RARELY (1/month or less)</th>
<th>SOMETIMES (2-4/month)</th>
<th>OFTEN (5-15/month)</th>
<th>ALMOST ALWAYS (16-30/month)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coughing or wheezing.</td>
<td>[ ] 1</td>
<td>[ ] 2</td>
<td>[ ] 3</td>
<td>[ ] 4</td>
<td>[ ] 5</td>
</tr>
<tr>
<td>Chest pain or tightness.</td>
<td>[ ] 1</td>
<td>[ ] 2</td>
<td>[ ] 3</td>
<td>[ ] 4</td>
<td>[ ] 5</td>
</tr>
<tr>
<td>Shortness of breath.</td>
<td>[ ] 1</td>
<td>[ ] 2</td>
<td>[ ] 3</td>
<td>[ ] 4</td>
<td>[ ] 5</td>
</tr>
<tr>
<td>Sweats or hot flashes.</td>
<td>[ ] 1</td>
<td>[ ] 2</td>
<td>[ ] 3</td>
<td>[ ] 4</td>
<td>[ ] 5</td>
</tr>
<tr>
<td>Noise in your surroundings.</td>
<td>[ ] 1</td>
<td>[ ] 2</td>
<td>[ ] 3</td>
<td>[ ] 4</td>
<td>[ ] 5</td>
</tr>
<tr>
<td>Pain in your joints, muscles, or back.</td>
<td>[ ] 1</td>
<td>[ ] 2</td>
<td>[ ] 3</td>
<td>[ ] 4</td>
<td>[ ] 5</td>
</tr>
<tr>
<td>Heartburn or indigestion.</td>
<td>[ ] 1</td>
<td>[ ] 2</td>
<td>[ ] 3</td>
<td>[ ] 4</td>
<td>[ ] 5</td>
</tr>
<tr>
<td>Leg cramps or leg jerks.</td>
<td>[ ] 1</td>
<td>[ ] 2</td>
<td>[ ] 3</td>
<td>[ ] 4</td>
<td>[ ] 5</td>
</tr>
<tr>
<td>Need to go to the bathroom.</td>
<td>[ ] 1</td>
<td>[ ] 2</td>
<td>[ ] 3</td>
<td>[ ] 4</td>
<td>[ ] 5</td>
</tr>
</tbody>
</table>
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.)

<table>
<thead>
<tr>
<th>Situation</th>
<th>NO CHANCE</th>
<th>SLIGHT CHANCE</th>
<th>MODERATE CHANCE</th>
<th>HIGH CHANCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sitting and reading. A.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Watching TV. B.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sitting inactive in a public place (such as a theater or a meeting).</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Riding as a passenger in a car for an hour without a break.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lying down to rest in the afternoon when circumstances permit.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sitting and talking to someone.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sitting quietly after a lunch without alcohol.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In a car, while stopped for a few minutes in traffic.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>At the dinner table.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>While driving.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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 ☐ 2 Spanish ☐ 3 Lakota ☐ 4 Other, specify: ________________________________

☐ 1 English ☐ 2 Pima ☐ 3 Unknown

Interviewer or Reviewer ______ ______ ______ Date: INTDT02 ______ ______ ______
month day year