The first set of questions are about your activities over the past 24 hours.

1. Please indicate what time you fell asleep last night: _____ Circle AM or PM

2. How well did you sleep (check one)? _____ Better than usual
_____ As well as usual
_____ Worse than usual

3. What time did you wake up today? _____ Circle AM or PM

4. Did you take any naps today? ___Yes ___No

If yes, what time did you nap: _____ How long did you sleep? _____ #minutes

5. How was your day today (check one)? _____ A very typical day
_____ Less stressful than usual
_____ More stressful than usual

6. Do you have any physical problems or discomforts tonight? ___Yes ___No
If yes, indicate what:_____

The next few questions are about any medicines or drugs that you take daily or almost daily.

7. Do you regularly take any medicines? ___Yes ___No

If yes, please list the name of each drug and indicate if it was taken today:

Name of drug	Taken today?
a. _____	_____Yes _____No
b. _____	_____Yes _____No
c. _____	_____Yes _____No
d. _____	_____Yes _____No
e. _____	_____Yes _____No
f. _____	_____Yes _____No
g. _____	_____Yes _____No
h. _____	_____Yes _____No
i. _____	_____Yes _____No

8. Have you taken any other kind of drug today? _____Yes _____No

If yes, indicate what:_____

9. Do you **routinely** take any of the following over-the-counter medications?

a. Sleeping aids or sedatives, like Sominex ___Yes ___No
b. Stimulants, like No-Doze ___Yes ___No
c. Appetite depressants for dieting ___Yes ___No

10. How many cups of coffee or tea, **with caffeine**, do you usually drink in a typical day? _____

11. How many cans of cola or other soft drinks, **with caffeine**, do you usually drink in a typical day? _____

12. What is your current occupation/job title? _____

13. For your job, do you work (check one):

_____Daytime hours _____ Night shift _____Rotating shift _____Does not apply

14. Which category below best fits your experience with weight control (check one)?

_____ My weight is fairly stable without any dieting or exercise.
_____ I tend to gain weight, but can control it by dieting or exercise.
_____ I tend to gain weight, in spite of efforts to control it.
_____ I tend to lose weight.
_____ I tend to gain weight.

15. Please estimate the total miles per year **you, as the driver**, drive a car. _____ Miles/Year

The next set of questions are about your health and medical history.

16. Have you had any nasal congestion or stuffiness **today or tonight** (check one)?

____None ____Today ____Tonight ____Both

17. Do you have any other problems, such as an illness, allergy, deviated septum or structural problem, or sensitivity that always or always cause nasal stuffiness **at night**?

___No ___Yes **If yes**, indicate what (please be specific): _____

_____

18. Have you ever had any pain or discomfort in your chest? ___Yes ___No (**If no**, skip to 26.)

19. Do you get it when you walk uphill or hurry? ___Yes ___No ___I never hurry or walk uphill

20. Do you get it when you walk at an ordinary pace on the level? ___Yes ___No

♦If you answered "yes" to either question 19 or 20 please complete questions 21 thru 25.
♦If you answered "no" to both question 19 and 20 please skip to question 25.

21. What do you do if you get it while you are walking?
_____ Take nitroglycerin
_____ Stop or slow down
_____ Carry on

22. If you stand still, how soon does the pain go away?
_____ 10 minutes or less
_____ More than 10 minutes
_____ Does not go away

23. Where does the pain occur (*check all that apply*)?
_____ Upper or middle breastbone
_____ Lower chest
_____ Left side of chest
_____ Left arm
_____ Other:_____

24. Do you feel it anywhere else? ___No ___Yes **If yes**, where:_____

25. Have you ever had a severe pain across the front of your chest lasting for 1/2 hour or more?
___Yes ___No

26. Do you get pain in either leg on walking? ___Yes ___No **If no**, skip to 34.

27. Does this leg pain ever begin when you are standing still or sitting? ___Yes ___No

28. In what part of your leg do you feel it? _____ Pain included calf/calves
_____ Pain does not include calf/calves
_____ Other_____

29. Do you get it if you walk uphill or hurry? ___Yes ___No ___I never hurry or walk uphill

30. Do you get it if you walk at an ordinary pace on the level? ___Yes ___No

31. Does the pain ever disappear while you are walking? ___Yes ___No

32. What do you usually do if you get it when you are walking? _____ Stop or slow down
_____ Carry on

33. If you stand still, how soon does the pain go away? _____ 10 minutes or less
_____ More than 10 minutes
_____ Does not go away

The next section asks about specific medical problems. Please indicate if you have been told *by a doctor* that you have or have had any of these conditions.

34. Heart disease:

a. Coronary artery disease? ___Yes ___No

If yes, indicate how many years ago ____ or the year ____ you were diagnosed.

Also, describe what, if any, treatment you received.

_____

b. Atherosclerosis (hardening of the arteries)? ___Yes ___No

If yes, indicate how many years ago ____ or the year ____ you were diagnosed.

Also, describe what, if any, treatment you received.

_____

c. Irregular heartbeat or arrhythmia? ___Yes ___No

If yes, indicate how many years ago ____ or the year ____ you were diagnosed.

Also, describe what, if any, treatment you received.

_____

d. Heart attack or infarct? ___Yes ___No

If yes, indicate how many years ago ____ or the year ____ you were diagnosed.

Also, describe what, if any, treatment you received.

_____

e. Congestive heart failure? ___Yes ___No

If yes, indicate how many years ago ____ or the year ____ you were diagnosed.

Also, describe what, if any, treatment you received.

_____

f. Angina? ___Yes ___No

If yes, indicate how many years ago ____ or the year ____ you were diagnosed.

Also, describe what, if any, treatment you received.

_____

g. Have you ever had any of the following surgical procedures? ___Yes ___No

If yes, check <u>all</u> that apply: ____Coronary bypass surgery
____Coronary or balloon angioplasty
____Insertion of pacemaker or defibrillator
____Other heart surgery/please describe: _____
_____

35. High blood pressure or hypertension? ___Yes ___No

If yes, indicate how many years ago ____ or the year ____ you were diagnosed.

Also, describe what, if any, treatment you received.

_____

36. Stroke? ___Yes ___No

If yes, indicate how many years ago ____ or the year ____ you were diagnosed.

Also, describe what, if any, treatment you received.

_____

37. Diabetes? ___Yes ___No

If yes, indicate how many years ago ____ or the year ____ you were diagnosed.

Also, describe what, if any, treatment you received.

_____

38. Asthma? ___Yes ___No

If yes, indicate how many years ago ____ or the year ____ you were diagnosed.

Also, describe what, if any, treatment you received.

_____

39. Emphysema or Obstructive Lung Disease? ___Yes ___No

If yes, indicate how many years ago ____ or the year ____ you were diagnosed.

Also, describe what, if any, treatment you received.

_____

40. Thyroid problem? ___Yes ___No

If yes, indicate how many years ago ____ or the year ____ you were diagnosed.

Also, describe what, if any, treatment you received.

_____

41. Epilepsy or convulsions? ___Yes ___No

If yes, indicate how many years ago ____ or the year ____ you were diagnosed.

Also, describe what, if any, treatment you received.

_____

42. Arthritis? ___Yes ___No

If yes, indicate how many years ago ____ or the year ____ you were diagnosed.

Also, describe what, if any, treatment you received.

_____

43. **Since your last study** have you had any chronic joint or back pain? ___Yes ___No

If yes, when did it occur? _____ Month/Year

Please describe it:_____

44. **Since your last study** have you had any major illness or hospitalization? ___Yes ___No

If yes, when did it occur? _____ Month/Year

Please describe it:_____

45. **Since your last overnight sleep study** have you had any dental work, like braces, retainers, or dentures to change your bite or jaw position? ___Yes ___No

If yes, what was done? _____

When was the work done? _____ Month/Year

46. **Since your last overnight sleep study** have you had an injury to or surgery on your nose or face? ___Yes ___No

If yes, when did it occur? _____ Month/Year

Please describe it:_____

The next few questions are about your typical alcohol use and smoking habits. We realize that most people's habits vary a lot, depending on their weekly social plans and so on, but we hope to get an idea of your "usual" or average use.

47. Please estimate your **usual** consumption of alcoholic beverages:

a. How many cans or bottles of beer might you have per week? _____
b. How many glasses of wine might you have per week? _____

c. How many mixed drinks or shots might you have per week? _____
d. If you do not drink alcoholic beverages at all check here ____ and skip to question 51.

48. How many nights, during a typical week, might you have an alcoholic drink within 1 hour of bedtime? _____ # of nights

49. Have you had any alcoholic beverages today? ___Yes ___No

If yes, at about what time was that? _____ Circle AM or PM

How many? _____ # of drinks

50. Is your current amount of drinking fairly typical of your habits over the last 5 years? ___Yes ___No

If no, how is your drinking different from the past (*check <u>one</u>*)?

____ Drink a little less now
____ Drink much less now
____ Stopped drinking
____ Drink a little more now
____ Drink much more now
____ Other, please explain:_____

51. Have you ever smoked tobacco regularly? ___Yes ___No **If no**, skip to 53.

52. Do you currently smoke? ___Yes ___No **If no**, when did you quit? _____Year

How much do you smoke now, **OR** if you quit smoking, how much did you smoke in the past (*answer <u>all</u> that apply*)?

_____Cigarettes per day **OR** _____packs per week;
_____Bowls of pipe tobacco per day; and
_____Cigars per day.

Overall, how many years total, have you been **OR** were you a regular smoker? _____Year

<u>The next series of questions concern how you generally feel.</u>

53. Do you **usually** feel tired or fatigued at times **<u>during a typical day</u>**? ___Yes ___No

If yes, does the tiredness interfere with your (*check <u>all</u> that apply*):

_____Work
_____Mood
_____Relationships with people
_____Enjoyment of life
_____Ability to concentrate
_____Motivation
_____Housework
_____Other
_____None of the above, tiredness does not interfere with my activities.

54. Many people have periods of low energy or fatigue, but, **<u>during a typical day</u>** do you experience excessive sleepiness when it is difficult to fight an **<u>uncontrollable urge to fall asleep</u>**? ___Yes ___No

If yes, does the tiredness interfere with your (*check <u>all</u> that apply*):

_____Work
_____Mood
_____Relationships with people
_____Enjoyment of life

_____Ability to concentrate
_____Motivation
_____Housework
_____Other
_____None of the above, tiredness does not interfere with my activities.

Do you know why you have periods of sleepiness? ___Yes ___No

If yes, what is the reason(s)?_____

55. How often, **on average**, do you take a nap during the day or the evening (*check one*)?

____Never, or less than once a month
____On a few days per month
____Irregularly, but at least once a week
____Every day or almost every day

The following questions concern your sleep habits.

56. According to what other have told you or to your own awareness, how often do you snore?

____Never or rarely - only once or a few times ever.
____Sometimes - a few nights per month; under special circumstances.
____At least once a week, but pattern may be irregular.
____Several (3 to 5) nights per week.
____Every night or almost every night.
____Do not know.

57. How loud do you think, or have others said, your snoring is?

____Only slightly louder than heavy breathing.
____About as loud as mumbling or talking.
____Louder than talking.
____Extremely loud, can be heard through a closed door.
____Do not know.
____Does not apply.

58. According to what others have told you, how often, if ever, do you gasp, choke, or make snorting sounds during sleep?

____Never or rarely - only once or a few times ever.
____Sometimes - a few nights per month; under special circumstances.
____At least once a week, but pattern may be irregular.
____Several (3 to 7) nights per week.
____Do not know.

59. How often, if ever, have you awakened suddenly with the feeling of gasping or choking?

____Never or rarely - only once or a few times ever.
____Sometimes - a few nights per month; under special circumstances.
____At least once a week, but pattern may be irregular.
____Several (3 to 7) nights per week.
____Do not know.

60. According to what others have told you, or to your own awareness, how often, if ever, do you have momentary periods during s when you stop breathing or you breathe abnormally?

____Never or rarely - only once or a few times ever.
____Sometimes - a few nights per month; under special circumstances.
____At least once a week, but pattern may be irregular.
____Several (3 to 7) nights per week.
____Do not know.

61. According to what others have told you, how often, if ever, do you kick or make other disruptive movements during sleep?

____Never or rarely - only once or a few times ever.
____Sometimes - a few nights per month; under special circumstances.
____At least once a week, but pattern may be irregular.
____Several (3 to 7) nights per week.
____Do not know.

62. How many hours of sleep do you usually get during:

a. a workday night? _____#hours
b. a weekend or nonwork night? _____#hours
c. a typical week from daytime or evening **naps**? _____#hours (*Enter 0 if none*)

63. About how many minutes does it **usually** take you to fall asleep at night? _____#minutes

64. How often, if ever, do you have any of the following problems sleeping? (*Circle one response for each item*.)

0=Never
1=Rarely (once a month)
2=Sometimes (2-4 times a month)
3=Often (5-15 times a month)
4=Almost always (16-30 times a month)

a. Do you have difficulty getting to sleep?	0	1	2	3	4
b. Do you wake up during the night and have a hard time getting back to sleep?	0	1	2	3	4
c. Do you wake up repeatedly during the night?	0	1	2	3	4
d. Do you wake up too early in the morning and can't get back to sleep?	0	1	2	3	4
e. Do you not feel rested during the day no matter how many hours of sleep you had?	0	1	2	3	4
f. Do you find it very difficult to wake up in the morning?	0	1	2	3	4
g. Do you have nightmares or disturbing dreams?	0	1	2	3	4
h. Do you have feeling of excessive daytime sleepiness?	0	1	2	3	4
i. When you laugh or become very angry or excited, do you ever have the feeling of "weak knees" or starting to fall down or feel the need to sit down?	0	1	2	3	4
j. Have you ever had the feeling that you cannot move your arms and legs, or any part of your body, when you arefalling asleep at night or when you are waking up in the orning?	0	1	2	3	4
k. Have you ever awakened during your night's sleep and had the feeling that you cannot move your arms and legs, or any part of your body?	0	1	2	3	4

The next set of questions are about getting medical care for any sleep problem.

65. Have you ever **gone to a doctor** for any **sleep problem**? ___Yes ___No

If yes, please indicate when _____(Month/Year) and answer the following questions:

a. What kind of doctor (general, family, sleep medicine, etc.) did you see?

_____

b. What, tests, if any, were done? _____

c. Did you see a doctor due to the results of your last sleep study in our lab? ___Yes ___No

d. What sleep problem(s) were you trying to get help for? _____

_____

66. Have you ever been **told by a doctor** that you have **sleep apnea**? ___Yes ___No

If yes, when was this? _____ Month/Year

What tests, if any, were done? _____

Were you told you needed treatment? ___Yes ___No

If yes, what treatment was recommended? _____

Did you have the treatment? ___Yes ___No

If yes, when did you first have the treatment? _____ Month/Year

Did the treatment help (*check one*)? _____Not at all
_____Helped a little
_____Helped moderately
_____Helped a lot

Comments:_____

If the treatment was CPAP or BiPAP please answer the following questions:

If you are not using the recommended CPAP/BiPAP, please explain why.

_____

If you are using the recommended CPAP/BiPAP, please indicate:

a. How many nights per week do you use it? _____
b. How many hours per night do you use it? _____

Describe the problems, if any, you have with the CPAP/BiPAP: _____

_____

67. Have you ever been **told by a doctor** that you have **narcolepsy**? ___Yes ___No

If yes, when was this? _____ Month/Year

What tests, if any, were done? _____

Were you told you needed treatment? ___Yes ___No

If yes, what treatment was recommended? _____

Did you have the treatment? ___Yes ___No

If yes, when did you first have the treatment? _____ Month/Year

Did the treatment help (*check one*)? _____Not at all
_____Helped a little
_____Helped moderately
_____Helped a lot

Comments:_____

68. Have you ever been **told by a doctor** that you had any **other sleep disorder**? ___Yes ___No

If yes, what sleep disorder were you told you had? _____

When was this? _____ Month/Year

What tests, if any, were done? _____

Were you told you needed treatment? ___Yes ___No

If yes, what treatment was recommended? _____

Did you have the treatment? ___Yes ___No

If yes, when did you first have the treatment? _____ Month/Year

Did the treatment help (*check one*)? _____Not at all
_____Helped a little
_____Helped moderately
_____Helped a lot

Comments:_____

69. Other than what you have described above, have you ever tried to get medical care for a sleep disorder but were told you did not need to be tested or examined? ___Yes ___No

If yes, when was this? _____ Month/Year

What was the problem(s) you were trying to get help for? _____

_____

What kind of doctor (general, family, sleep medicine, etc.) did you contact? _____

What did the doctor tell you? _____

_____

The final section concerns your general health and the quality of your sleep.

70. Are you satisfied with your **usual** night's sleep (*check one*)?

____Most of the time ____Not usually

____Some of the time ____Never

If there are any comments you would like to make about the quality of your sleep, or getting to sleep, staying asleep, or waking up please use the following space: _____

_____

71. How satisfied are you with the way you are spending your life (*check one*)?

_____Completely satisfied
_____Mostly satisfied
_____Moderately satisfied
_____Not very satisfied

72. In general, would you say your health is (*check one*):

_____Excellent
_____Very good
_____Good
_____Fair
_____Poor

Thank you for taking the time to complete this self-administered questionnaire. The details you have provided will be used to bette understand what factors may contribute to sleep disordered breathing, and what other health risks may be the result of sleep disordered breathing.

Date: _____