

typical day? _____

(cans_cola)

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

(type_work) (code_occupation)

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

1 Daytime hours 2 Night shift 3 Rotating shift 8 Does not apply
(type_shift)

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

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

(weight_contr)

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

(drive_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)?

N None 1 Today 2 Tonight 3 Both
(nasal_cong)

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**?

(nasal_other)

N No Y Yes **If yes**, indicate what (please be specific): _____

____ (nasal_other1, nasal_other2, nasal_other3) (code_stuffiness) _____

18. Have you ever had any pain or discomfort in your chest? Y Yes N No (**If no**, skip to 26.)

(pain)

19. Do you get it when you walk uphill or hurry? Y Yes N No D I never hurry or walk uphill

(pain_hill)

20. Do you get it when you walk at an ordinary pace on the level? Yes No

(pain_pace)

◆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? 1 Take nitroglycerin

2 Stop or slow down

3 Carry on

(pain_action)

22. If you stand still, how soon does the pain go away? 1 10 minutes or less

2 More than 10 minutes

3 Does not go away

(pain_time)

23. Where does the pain occur (*check all that apply*)? pain_breastbone 01 Upper or middle breastbone

pain_lower_chest 01 Lower chest

(pain_where1, pain_where2, pain_where3, pain_left_chest 01 Left side of chest

pain_where4, pain_where5) pain_left_arm 01 Left arm

(pain_where51, pain_where52, pain_where53) pain_occurs_other 01 Other: (3 fields see left)

(code_chest_pain)

24. Do you feel it anywhere else? N No Y Yes **If yes**, where: (pain_other1-3) (code_chest_pain) _____

(pain_other)

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

Y Yes N No

(pain_front)

26. Do you get pain in either leg on walking? Y Yes N No **If no**, skip to 34.

(leg)

27. Does this leg pain ever begin when you are standing still or sitting? Y Yes N No

(leg_still)

28. In what part of your leg do you feel it? 1 Pain included calf/calves

(leg_where1, leg_where2, leg_where3) 2 Pain does not include calf/calves

(leg_where31, leg_where32, leg_where33) 3 Other _____

(code_leg_pain)

29. Do you get it if you walk uphill or hurry? Y Yes N No D I never hurry or walk uphill

(leg_hill)

30. Do you get it if you walk at an ordinary pace on the level? Y Yes N No

(leg_pace)

31. Does the pain ever disappear while you are walking? Y Yes N No

(leg_disappear)

32. What do you usually do if you get it when you are walking? 1 Stop or slow down

2 Carry on

(leg_action)

33. If you stand still, how soon does the pain go away? 1 10 minutes or less

2 More than 10 minutes

3 Does not go away

(leg_time)

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.

Note: second and third treatment fields added in the late summer of 2011

34. Heart disease:

a. Coronary artery disease? Yes No

(coronary_ynd)

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

(coronary_year)

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

 (coronary_tx,tx2,tx3) (code_medical_treatment) _____

b. Atherosclerosis (hardening of the arteries)? Yes No

(atheroscl_ynd)

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

(atheroscl_year)

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

 (atheroscl_tx,tx2,tx3) (code_medical_treatment) _____

c. Irregular heartbeat or arrhythmia? Yes No

(arrhythmia_ynd)

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

(arrhythmia_year)

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

 (arrhythmia_tx,tx2,tx3) (code_medical_treatment) _____

d. Heart attack or infarct? Yes No

(heartattack_ynd)

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

(heartattack_year)

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

 (heartattack_tx,tx2,tx3) (code_medical_treatment) _____

e. Congestive heart failure? Yes No

(congestivehf_ynd)

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

(congestivehf_year)

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

_____ (congestivehf_tx,tx2,tx3) _____ (code_medical_treatment) _____

f. Angina? ___ Yes ___ No

(angina_ynd)

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

(angina_year)

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

__ (angina_tx,tx2,tx3) _____ (code_medical_treatment) _____

g. Have you ever had any of the following surgical procedures? ___ Yes ___ No

If yes, check all that apply: _____ Coronary bypass surgery (coronarybypass_ynd)

_____ Coronary or balloon angioplasty (angioplasty_ynd)

_____ Insertion of pacemaker or defibrillator (pacemaker_ynd)

_____ Other heart surgery/please describe: _____

(other_heart_surgery_ynd) _____

(other_heart_surg_code1, other_heart_surg_code2, other_heart_surg_code3) (code_medical_treatment)

35. High blood pressure or hypertension? ___ Yes ___ No

(hypertension_ynd)

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

(hypertension_year)

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

_ (hypertension_tx,tx2,tx3) _____ (code_medical_treatment) _____

36. Stroke? ___ Yes ___ No

(stroke_ynd)

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

(stroke_year)

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

__ (stroke_tx,tx2,tx3) _____ (code_medical_treatment) _____

37. Diabetes? ___ Yes ___ No

(diabetes_ynd)

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

(diabetes_year)

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

__ (diabetes_tx,tx2,tx3) _____ (code_medical_treatment) _____

38. Asthma? ___ Yes ___ No

(asthma_ynd)

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

(asthma_year)

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

_ (asthma_tx,tx2,tx3) _____ (code_medical_treatment) _____

39. Emphysema or Obstructive Lung Disease? ___ Yes ___ No

(emphysema_ynd)

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

(emphysema_year)

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

__ (emphysema_tx,tx2,tx3) _____ (code_medical_treatment) _____

40. Thyroid problem? ___ Yes ___ No

(thyroid_ynd)

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

(thyroid_year)

Also, describe the type of thyroid problem (thyroid_problem_code (code_medical_treatment)) and what, if any, treatment you received.

_____ (thyroid_tx,tx2,tx3) _____ (code_medical_treatment) _____

41. Epilepsy or convulsions? ___ Yes ___ No

(epilepsy_ynd)

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

(epilepsy_year)

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

_____ (epilepsy_tx,tx2,tx3) _____ (code_medical_treatment) _____

42. Arthritis? ___ Yes ___ No

(arthritis_ynd)

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

(arthritis_year)

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

_____ (arthritis_tx,tx2,tx3) _____ (code_medical_treatment) _____

43. Since your last study have you had any chronic joint or back pain? ___ Yes ___ No

(backpain)

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

(back_year1, back_year2, back_year3)

Please describe it: ___ (back_code1, back_code2) (code_joint_back_pain) _____

44. Since your last study have you had any major illness or hospitalization? ___ Yes ___ No

(illness)

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

(illness_year1, illness_year2, illness_year3, illness_year4)

Please describe it: ___ (ill_code1, ill_code2, ill_code3, ill_code4) (code_major_illness) _____

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

(dental_work)

If yes, what was done? (dental_desc1, dental_desc2) _____ (code_change_in_bite) _____

When was the work done? _____ Month/Year

(dental_year1, dental_year2)

46. Since your last overnight sleep study have you had an injury to or surgery on your nose or face? ___ Yes ___ No

(inj_surgery)

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

(inj_year1, inj_year2)

Please describe it: ___ (inj_desc1, inj_desc2) ___ (code_facial_injury_surgery) _____

(Note on older versions of overnight interview asked if tonsils removed (tonsils, tonsils_year) and adenoids removed (adenoids, adenoids_year))

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? _____ (beer_week)
 b. How many glasses of wine might you have per week? _____ (wine_week)
 c. How many mixed drinks or shots might you have per week? _____ (hard_week)
 d. If you do not drink alcoholic beverages at all check here _____ and skip to question 51.
 (nondrinker)

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

49. Have you had any alcoholic beverages today? ___ Yes ___ No (drink_24hrs)

If yes, at about what time was that? _____ Circle AM or PM (drink_time) (entered as military)

How many? _____ # of drinks (drink_number)

50. Is your current amount of drinking fairly typical of your habits over the last 5 years? ___ Yes ___ No
 (drink_past5y)

If no, how is your drinking different from the past (*check one*)? drink_past

- ___1___ Drink a little less now
 ___2___ Drink much less now
 ___3___ Stopped drinking
 ___4___ Drink a little more now
 ___5___ Drink much more now
 ___6___ Other, please explain: _____

51. Have you ever smoked tobacco regularly? ___ Yes ___ No **If no**, skip to 53.
 (smoke)

52. Do you currently smoke? ___ Yes ___ No **If no**, when did you quit? _____ Year
 (smoke_curr) (smoke_quit)

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

- _____ Cigarettes per day **OR** _____ packs per week; (packs_week)
 _____ Bowls of pipe tobacco per day; and (bowls_day)
 _____ Cigars per day. (cigars_day)

Overall, how many years total, have you been **OR** were you a regular smoker? _____ Year
 (smoke_years)

The next series of questions concern how you generally feel.

53. Do you **usually** feel tired or fatigued at times **during a typical day**? ___ Yes ___ No
 (fatigued)

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

- _____ Work (fatigue_work)
 _____ Mood (fatigue_mood)
 _____ Relationships with people (fatigue_relationships)
 _____ Enjoyment of life (fatigue_enjoyment_of_life)
 _____ Ability to concentrate (fatigue_concentrate)
 _____ Motivation (fatigue_motivation)
 _____ Housework (fatigue_housework)
 _____ Other (fatigue_other)
 _____ None of the above, tiredness does not interfere with my activities. (fatigue_none)

54. Many people have periods of low energy or fatigue, but, **during a typical day**, do you experience excessive sleepiness when it is difficult to fight an **uncontrollable urge to fall asleep**? ___ Yes ___ No
 (sleepiness)

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

- Work (*sleepiness_work*)
 Mood (*sleepiness_mood*)
 Relationships with people (*sleepiness_relationships*)
 Enjoyment of life (*sleepiness_enjoyment_of_life*)
 Ability to concentrate (*sleepiness_concentrate*)
 Motivation (*sleepiness_motivation*)
 Housework (*sleepiness_housework*)
 Other (*sleepiness_other*)
 None of the above, tiredness does not interfere with my activities. (*sleepiness_none*)

Do you know why you have periods of sleepiness? ___ Yes ___ No
 (*sleep_why*)

If yes, what is the reason(s)? ___ (*sleep_reas1, sleep_reas2, sleep_reas3*) _____
 (*code_sleepiness*)

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

- 1 Never, or less than once a month
 2 On a few days per month
 3 Irregularly, but at least once a week
 4 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?
 (*snore_freq*)

- 1 Never or rarely - only once or a few times ever.
 2 Sometimes - a few nights per month; under special circumstances.
 3 At least once a week, but pattern may be irregular.
 4 Several (3 to 5) nights per week.
 5 Every night or almost every night.
 9 Do not know.

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

- 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.
 9 Do not know.
 8 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?

(*choke_freq*)

- 1 Never or rarely - only once or a few times ever.
 2 Sometimes - a few nights per month; under special circumstances.
 3 At least once a week, but pattern may be irregular.
 4 Several (3 to 7) nights per week.
 9 Do not know.

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

- 1 Never or rarely - only once or a few times ever.
 2 Sometimes - a few nights per month; under special circumstances.
 3 At least once a week, but pattern may be irregular.
 4 Several (3 to 7) nights per week.

9 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 : when you stop breathing or you breathe abnormally?

(apnea_freq)

- 1 Never or rarely - only once or a few times ever.
- 2 Sometimes - a few nights per month; under special circumstances.
- 3 At least once a week, but pattern may be irregular.
- 4 Several (3 to 7) nights per week.
- 9 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?

(kick_freq)

- 1 Never or rarely - only once or a few times ever.
- 2 Sometimes - a few nights per month; under special circumstances.
- 3 At least once a week, but pattern may be irregular.
- 4 Several (3 to 7) nights per week.
- 9 Do not know.

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

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

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

(tso)

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?
(ps_diff) | 0 | 1 | 2 | 3 | 4 |
| b. Do you wake up during the night and have a hard time getting back to sleep?
(ps_backsleep) | 0 | 1 | 2 | 3 | 4 |
| c. Do you wake up repeatedly during the night?
(ps_wakerepeat) | 0 | 1 | 2 | 3 | 4 |
| d. Do you wake up too early in the morning and can't get back to sleep?
(ps_tooearly) | 0 | 1 | 2 | 3 | 4 |
| e. Do you not feel rested during the day no matter how many hours of sleep you had?
(ps_notrested) | 0 | 1 | 2 | 3 | 4 |
| f. Do you find it very difficult to wake up in the morning?
(ps_wakeup) | 0 | 1 | 2 | 3 | 4 |
| g. Do you have nightmares or disturbing dreams?
(ps_nightmare) | 0 | 1 | 2 | 3 | 4 |
| h. Do you have feeling of excessive daytime sleepiness?
(ps_ed) | 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?
(ps_weak) | 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 are falling asleep at night or when you are waking up in the morning? | 0 | 1 | 2 | 3 | 4 |

(ps_move)

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

(ps_movesleep)

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

(sleep_prob)

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

(prob_date)

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

__ (prob_doc1, prob_doc2, prob_doc3) _____ (code_physician) _____

b. What, tests, if any, were done? __ (prob_test1, prob_test2, prob_test3) _____
(code_sleep_testing)

(this question was added later)

c. Did you see a doctor due to the results of your last sleep study in our lab? ___ Yes ___ No

(prob_study)

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

__ (prob_code1, prob_code2, prob_code3) _____ (code_sleep_disorder) _____

66. Have you ever been **told by a doctor** that you have **sleep apnea**? ___ Yes ___ No

(apnea)

If yes, when was this? _____ Month/Year

(apnea_date)

What tests, if any, were done? __ (apnea_test1, apnea_test2, apnea_test3) _____
(code_sleep_testing)

Were you told you needed treatment? ___ Yes ___ No

(apnea_need)

If yes, what treatment was recommended? __ (apnea_treat1, apnea_treat2, apnea_treat3) __
(code_treatment)

Did you have the treatment? ___ Yes ___ No

(apnea_treated)

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

(treatment_date)

Did the treatment help (*check one*)? ___1___ Not at all
___2___ Helped a little
___3___ Helped moderately
___4___ Helped a lot

(treatment_help)

Comments: __ (treat_com1, treat_com2, treat_com3) _____ (code_comment_dx_sleep_disorder) __

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

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

__ (noncompl1, noncompl2, noncompl3) _____ (code_cpap_bpap) _____

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

a. How many nights per week do you use it? _____ (comp_nights_wk)

b. How many hours per night do you use it? _____ (comp_hrnights)

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

_(comp_prob1, comp_prob2, comp_prob3) _____ (code_cpap_bipap) _____

67. Have you ever been **told by a doctor** that you have **narcolepsy**? ___ Yes ___ No

(narco)

If yes, when was this? _____ Month/Year

(narco_date)

What tests, if any, were done? _ (narco_test1, narco_test2, narco_test3) _____

(code_sleep_testing)

Were you told you needed treatment? ___ Yes ___ No

(narco_need)

If yes, what treatment was recommended? (narco_treat1, narco_treat2, narco_treat3) _____

(code_treatment)

Did you have the treatment? ___ Yes ___ No

(narco_treated)

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

(n_treat_date)

Did the treatment help (*check one*)? ___ 1 ___ Not at all

___ 2 ___ Helped a little

(n_treat_help) ___ 3 ___ Helped moderately

___ 4 ___ Helped a lot

Comments: _____ (n_treat_com1, n_treat_com2, n_treat_com3) _____

(code_comment_dx_sleep_disorder)

68. Have you ever been **told by a doctor** that you had any **other sleep disorder**? ___ Yes ___ No

(sd)

If yes, what sleep disorder were you told you had? _ (sd_code1, sd_code2, sd_code3) _____

(code_sleep_disorder)

When was this? _____ Month/Year

(sd_date)

What tests, if any, were done? _ (sd_test1, sd_test2, sd_test3) _____

(code_sleep_testing)

Were you told you needed treatment? ___ Yes ___ No

(sd_need)

If yes, what treatment was recommended? _ (sd_treat1, sd_treat2, sd_treat3) _____

(code_treatment)

Did you have the treatment? ___ Yes ___ No

(sd_treated)

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

(sd_treat_date)

Did the treatment help (*check one*)? ___ 1 ___ Not at all

___ 2 ___ Helped a little

(sd_treat_help) ___ 3 ___ Helped moderately

___ 4 ___ Helped a lot

Comments: _ (sd_treat_com1, sd_treat_com2, sd_treat_com3) _____

(code_comment_dx_sleep_disorders)

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

(other)

If yes, when was this? _____ Month/Year

(other_date)

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

___ (other_help1, other_help2, other_help3) _____

(code_sleep_disorders)

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

(other_doc1, other_doc2, other_doc3) (code_physician)

What did the doctor tell you? _ (other_com1, other_com2, other_com3) _____

(code_doctors_comments)

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*)?

- (eval_general)
- | | |
|------------------------|-------------------|
| __1__ Most of the time | __3__ Not usually |
| __2__ Some of the time | __4__ 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: _____

__ (comments1, comments2, comments3) _____ (code_sleep_comments) _____

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

- (eval_life)
- | |
|----------------------------|
| __1__ Completely satisfied |
| __2__ Mostly satisfied |
| __3__ Moderately satisfied |
| __4__ Not very satisfied |

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

- (eval_health)
- | |
|-----------------|
| __1__ Excellent |
| __2__ Very good |
| __3__ Good |
| __4__ Fair |
| __5__ Poor |

(note in the visit 1 interview only, asked these questions:

What country were you born in? country_born (999)

What nationalities do you identify most closely with? heritage1 heritage2 (999)

)

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

Date: ____interview_date_____