Wisconsin Sleep Cohort Survey

University of Wisconsin School of Medicine
Department of Preventive Medicine

1. Have you ever been told that you snore?
   1. Yes   2. No: [SKIP TO QUESTION 7]

2. Have any of these people told you that you snore?
   CHECK ALL THAT APPLY
   a. Someone sleeping in the **same** bedroom?
   b. Someone sleeping in other rooms?
   c. Persons who have been awake while you sleep or nap somewhere (sofa, car, etc.)?

3. According to what others have told you, please estimate how often you snore (CHECK ONE RESPONSE ONLY)
   1. 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) times per week.
   5. Every night or almost every night.
   7. Do not know.

4. How loud have others said your snoring is? (CHECK ONE RESPONSE ONLY)
   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.
   7. Do not know.

5. Has anyone who shared your bedroom ever moved, either temporarily or permanently to another bedroom (or had you move to another bedroom) due to your snoring?
   1. Yes   2. No

6. Based on what others have told you, about how many years do you think you have been snoring?
   ____ years **OR** □ Do not know.

7. Aside from what others may have told you, how often, if ever, have you had the feeling or awareness that you have been snoring? CHECK ONE RESPONSE ONLY
   1. Never
   2. Rarely – only once or a few times ever.
   3. Sometimes – a few nights per month
   4. Often – at least once a week, but pattern may be irregular
   5. Very often – every night or almost every night
   7. Not sure.

8. According to what others have told you, how often,if ever, do you gasp, choke, or make snorting sounds during sleep? CHECK ONE RESPONSE ONLY
   1. Never
   2. Rarely – only once or a few times ever.
   3. Sometimes – a few nights per month
   4. Often – at least once a week, but pattern may be irregular
   5. Very often – every night or almost every night.

7. Not sure

9. How often, if ever, have you wakened suddenly with the feeling of gasping or choking? CHECK ONE RESPONSE ONLY
   1. Never
   2. Rarely – only once or a few times ever.
   3. Sometimes – a few nights per month
   4. Often – at least once a week, but pattern may be irregular
   5. Very often – every night or almost every night
   7. Not sure.

10. According to what others have told you, how often, if ever, do you seem to have momentary periods during sleep when you stop breathing or you breathe abnormally? CHECK ONE RESPONSE ONLY
   1. Never
   2. Rarely – only once or a few times ever.
   3. Sometimes – a few nights per month
   4. Often – at least once a week, but pattern may be irregular
   5. Very often – every night or almost every night
   7. Not sure.

11. According to what others have told you, how often—if ever do you kick or make other disruptive movements during sleep? CHECK ONE RESPONSE ONLY
   1. Never [GO TO QUESTION 13]
   2. Rarely
   3. Sometimes
   4. Often
   5. Very often
   7. Not sure.

12. Has anyone who shared your bedroom ever moved to another bedroom (or had you move to another bedroom because of your kicking or disruptive movements?
   1 Yes 2 No

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

14. How many hours of sleep do you usually get during ...
   a. A workday night? # of hours ___
   a. A weekend or non-work night? # of hours ___
   a. A typical week from daytime or evening naps? □ None **OR** # of hours ___

15. Please indicate to what extent you have each of the following sleep problems. Circle one response for each problem.
   0=Never
   1=Rarely (once per month)
   2=Sometimes (2-4 times per month)
   3=Often (5-15 times per month)
   4=Almost always (16-30 times per month)

	Never	**Rarely**	**Sometimes**	**Often**	**Almost always**
a. Difficulty in getting to sleep.	0	1	2	3	4
b. Waking up during night and having a hard time getting back to sleep.	0	1	2	3	4

c. Waking up repeatedly during the night.	0	1	2	3	4
d. Waking up too early in the morning and can't get back to sleep.	0	1	2	3	4
e. Not feeling rested during the day, no matter how many hours of sleep you had.	0	1	2	3	4
f. Great difficulty waking up in morning.	0	1	2	3	4
g. Nightmares or disturbing dreams.	0	1	2	3	4
h. "Restless legs" or bothersome twitches.	0	1	2	3	4
i. Wake up with headaches.	0	1	2	3	4
j. Feelings of excessive daytime sleepiness.	0	1	2	3	4
k. Need to take sedatives or sleeping pills.	0	1	2	3	4
l. Nasal congestion, obstruction, or discharge at night.	0	1	2	3	4
m. Falling asleep or dozing momentarily while watching TV, reading, etc.	0	1	2	3	4
n. Falling asleep or dozing momentarily at meetings, church, etc.	0	1	2	3	4
o. Need for coffee or other stimulants to stay awake during the day.	0	1	2	3	4

16. Please check whether or not you have been **told by a doctor** that you had or have each condition below.

a. Sleep apnea (a condition where breathing stops momentarily during sleep).	1 Yes	2 No
b. Narcolepsy (inability to stay awake).	1 Yes	2 No
c. Asthma	1 Yes	2 No
d. Emphysema	1 Yes	2 No
e. Chronic bronchitis	1 Yes	2 No
f. Angina	1 Yes	2 No
g. Coronary heart disease or hardening of the arteries.	1 Yes	2 No
h. Heart attack	1 Yes	2 No
i. Stroke	1 Yes	2 No
j. Hypertension or high blood pressure.	1 Yes	2 No

17. Has a doctor treated you for Sleep Apnea?
1. Yes 2. No (SKIP TO QUESTION 19)

18. Describe the treatment you received.
____

19. What was your last blood pressure reading?
______ over ______ **OR** □ Do not know.

20. In what month and year was your blood pressure last taken?
Month __________
Year 19__________

21. Were you taking any medication to control your blood pressure at the time it was last taken?
1. Yes 2. No 7. Do not know.

22. Do you currently smoke cigarettes?
    1. Yes [SKIP TO QUESTION 24]   2. No

23. Have you **ever** smoked at least a pack a week?
    1. Yes   2. No [SKIP TO QUESTION 25]

24. About how much do you (or did you) smoke?
    # of packs per week _____

25. What are your age and sex?   _________ years
    1. Male   2. Female

26. What is your height without shoes?
    _________Feet   ________ Inches.

27. What is your present weight?   _______ Pounds.

28. What is your current martital status?
    1. Married
    2. Separated
    3. Divorced
    4. Widowed
    5. Single, never married

29.

How likely are you to doze off or fall asleep in the following situations? Circle one response for each situation.	**Chance of Dozing**			
	Never	Slight	Moderate	High
a. Sitting and reading	1	2	3	4
b. Watching TV	1	2	3	4
c. Sitting inactive in a public place (e.g. a theater or a meeting)	1	2	3	4
d. As a passenger in a car for an hour without a break	1	2	3	4
e. Lying down to rest in the afternoon when circumstances permit	1	2	3	4
f. Sitting and talking to someone	1	2	3	4
g. Sitting quietly after a lunch without alcohol	1	2	3	4
h. In a car while stopped for a few minutes in traffic	1	2	3	4
i. At the dinner table	1	2	3	4
j. While driving	1	2	3	4
k. During routine activities at work or home	1	2	3	4

Thank you for completing this survey. Please return the completed survey in the enclosed stamped envelope to:
Wisconsin Survey Research Laboratory
610 Langdon Street, Room 109
Madison, Wisconsin 53703