WISCONSIN SLEEP COHORT STUDY SURVEY

University of Wisconsin School of Medicine
Department of Preventive Medicine

Q1. Have you ever been told that you snore?

- ○ **Yes**
- ○ **No** ——— ***If no, skip to Question 4 on page 2.***

Q2. According to what others have told you, please estimate how often you snore. *(Please check one)*

- ○ **Rarely -- only once or a few times ever.**
- ○ **Sometimes -- a few nights per month.**
- ○ **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.**

Q3. How loud have others said your snoring is? *(Please check one)*

- ○ **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.**

Q4. Aside from what others have told you, how often, if ever, have you had the feeling or awareness that you have been snoring? (*Please check one)*

- ○ Never.
- ○ Rarely -- only once or a few times ever.
- ○ Sometimes -- a few nights per month.
- ○ Often -- at least once a week, but pattern may be irregular.
- ○ Very often -- every night or almost every night.
- ○ Not sure.

Q5. According to what others have told you, how often, if ever, do you gasp, choke, or make snorting sounds during sleep? (*Please check one)*

- ○ Never.
- ○ Rarely -- only once or a few times ever.
- ○ Sometimes -- a few nights per month.
- ○ Often -- at least once a week, but pattern may be irregular.
- ○ Very often -- every night or almost every night.
- ○ Do not know.

Q6. How often, if ever, have you awakened suddenly with the feeling of gasping or choking? (*Please check one)*

- ○ Never.
- ○ Rarely -- only once or a few times ever.
- ○ Sometimes -- a few nights per month.
- ○ Often -- at least once a week, but pattern may be irregular.
- ○ Very often -- every night or almost every night.
- ○ Not sure.

Q7. 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? *(Please check one)*

○ **Never.**

○ **Rarely -- only once or a few times ever.**

○ **Sometimes -- a few nights per month.**

○ **Often -- at least once a week, but pattern may be irregular.**

○ **Very often -- every night or almost every night.**

○ **Not sure.**

Q8. According to what others have told you, how often, if ever, do you kick or make other disruptive movements during sleep? *(Please check one)*

○ **Never.**

○ **Rarely -- only once or a few times ever.**

○ **Sometimes -- a few nights per month.**

○ **Often -- at least once a week, but pattern may be irregular.**

○ **Very often -- every night or almost every night.**

○ **Not sure.**

Q9. What best describes your work and sleep schedule? (*Please check one*)

○ **Work days, sleep nighttime hours.**

○ **Work nights, sleep daytime hours.**

○ **My schedule rotates.**

○ **Other, please explain:**

Q10. Please indicate to what extent you have each of the following sleep problems. *(Check one for each item)*

Sleep Problems	Never (0)	Rarely (1/mo)	Sometimes (2-4/mo)	Often (5-15/mo)	Almost Always (16-30/mo)

a. Difficulty getting to sleep.....○.....○.....○.....○.....○

b. Wake up during the night and have a hard time getting back to sleep.....○.....○.....○.....○.....○

c. Wake up repeatedly during the night.....○.....○.....○.....○.....○

d. Wake up too early in the morning and can't get back to sleep.....○.....○.....○.....○.....○

e. Not feel rested during the day, no matter how many hours of sleep you had....○.....○.....○.....○.....○

f. Very difficult to wake up in the morning.....○.....○.....○.....○.....○

g. Nightmares or disturbing dreams.....○.....○.....○.....○.....○

h. "Restless legs" or bothersome twitches.....○.....○.....○.....○.....○

i. Wake up with headaches....○.....○.....○.....○.....○

j. Feelings of excessive daytime sleepiness.....○.....○.....○.....○.....○

k. Need to take sedatives or sleeping pills.....○.....○.....○.....○.....○

l. Nasal congestion, obstruction, or discharge at night.....○.....○.....○.....○.....○

m. Need for coffee, or other stimulants to stay awake during the day.....○.....○.....○.....○.....○

Q11. About how many <u>minutes</u> does it usually take you to fall asleep at night?

minutes

Q12. 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?
(Complete one)

○ None **OR**

Q13. How often, when you are sitting or lying down, do you have any of the following feelings in your legs? *(Check one answer for each item)*

	Never	Less than once /month	Monthly	Weekly	Daily/ Nightly
a. Repeated urge to move your legs	○	○	○	○	○
b. Strange and uncomfortable feelings in your legs	○	○	○	○	○
c. Periods of several leg jerks or jumps in a row	○	○	○	○	○

IF YOU ANSWERED "NEVER" TO <u>ALL THREE</u> OF THESE QUESTIONS, PLEASE SKIP TO QUESTION 14.

d. Do these leg feelings just mentioned get better when you get up and start walking?

○ **Yes**

○ **No**

e. Do these leg feelings just mentioned disrupt your sleep?

○ Yes, some

○ Yes, a great deal

○ No

Q14. Please check whether or not you have been told by a doctor that you had or have each condition below.

Condition	Told by a doctor: Yes	No
a. Sleep apnea (a condition where breathing stops momentarily during sleep)	○	○
b. Narcolepsy (inability to stay awake)	○	○
c. Emphysema	○	○
d. Chronic bronchitis	○	○
e. Angina	○	○
f. Coronary heart disease or arteriosclerosis	○	○
g. Heart attack	○	○
h. Stroke	○	○
i. Hypertension or high blood pressure	○	○

j. Diabetes..... ○.....

○

Q15. Has a doctor treated you for Sleep Apnea?

○ Yes ——————*If yes, describe the treatment you received:*

○ No

Q16. In general, would you say your health is *(Please check one)***:**

○ Excellent

○ Very good

○ Good

○ Fair

○ Poor

Q17. Have you ever had any of the following procedures?
(Circle one answer for each item)

Condition	Yes	No	Not sure
a. Coronary bypass surgery (CABBAGE).....	○	○	○
b. Coronary angioplasty (balloon angioplasty).	○	○	○
c. Insertion of pacemaker (defibrillator).....	○	○	○
d. Other heart or cardiac surgery.....	○	○	○

Q18. Do you currently smoke cigarettes?

○ Yes

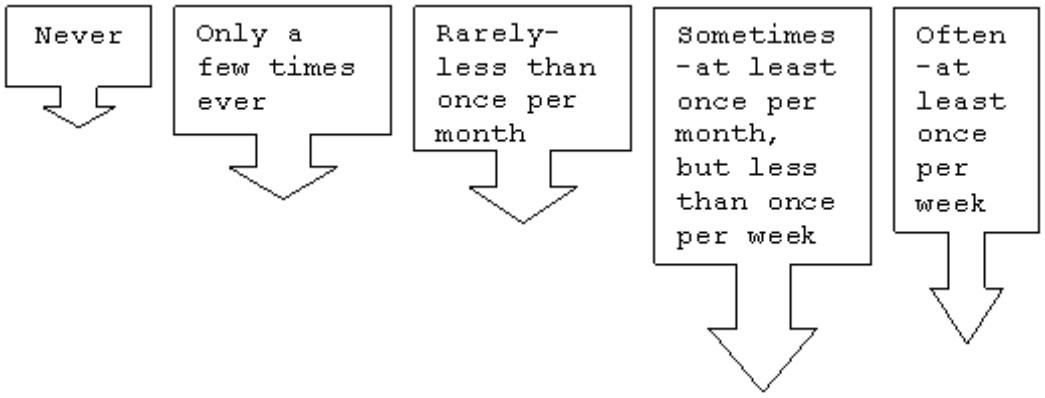
○ No

Q19. How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? (*Check one for each situation)*

Situation	Chance of Dozing: Never	Slight	Moderate	High	Does Not Apply
a. Sitting and reading	○	○	○	○	○
b. Watching TV	○	○	○	○	○
c. Sitting, inactive in a public place (e.g. a theater or a meeting)	○	○	○	○	○
d. As a passenger in a car for an hour without a break	○	○	○	○	○
e. Lying down to rest in the afternoon when circumstances permit	○	○	○	○	○
f. Sitting and talking to someone	○	○	○	○	○
g. Sitting quietly after lunch without alcohol	○	○	○	○	○
h. In a car, while stopped for a few minutes in traffic	○	○	○	○	○
i. At the dinner table	○	○	○	○	○
j. While driving	○	○	○	○	○
k. During routine					

activities at work or home.....○.....○.....○.....○.....○

Q20. Have you ever had episodes of muscle weakness in your legs or buckling of your knees...? *(Please check one for each item)*

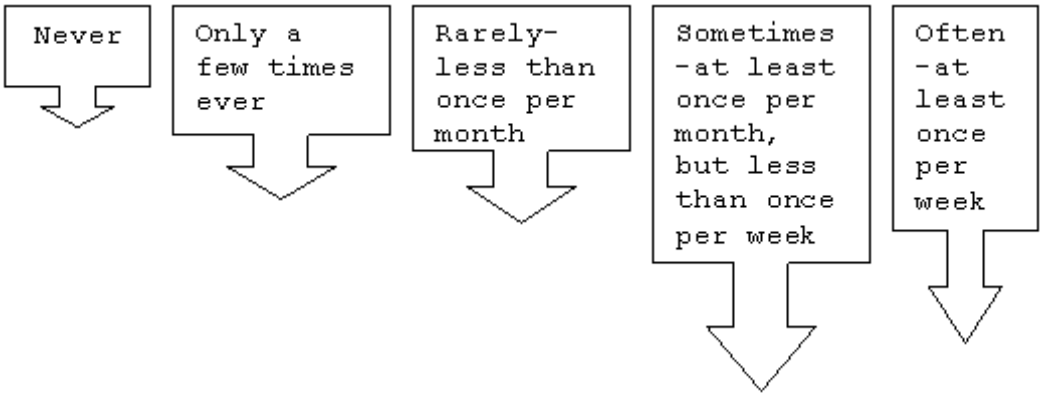


a. when you laugh..○.....○.....○.....○.....○

b. when you are angry.....○.....○.....○.....○.....○

c. when you tell or hear a joke..○.....○.....○.....○.....○

Q21. Have you ever imagined that you hear or see strange and frightening things or people...? *(Please check one for each item)*



a. when you are falling asleep at night.....○.....○.....○.....○.....○

b. when you wake up in the morning.....○.....○.....○.....○.....○

c. when you take a nap.....○.....○.....○.....○.....○

d. when you

are drowsy.....○.....○.....○.....○.....○.....○

Q22. Have you ever had times <u>when driving</u> when you suddenly felt like you "went blank" with no memory of that period of time? *(Circle one)*

○ Never.

○ Only a few times ever.

○ Rarely -- less than once per month.

○ Sometimes -- a least once per month, but less than once per week.

○ Often -- at least once a week.

Q23. Have you ever had times <u>when you were working at a desk or sitting quietly</u> when you suddenly felt like you "went blank" with no memory of that period of time? *(Please check one)*

○ Never.

○ Only a few times ever.

○ Rarely -- less than once per month.

○ Sometimes -- a least once per month, but less than once per week.

○ Often -- at least once a week.

Q24. Have you ever awakened <u>in the morning</u> and found you were unable to move your whole body and felt paralyzed? *(Please check one)*

○ Never.

○ Only a few times ever.

○ Rarely -- less than once per month.

○ Sometimes -- a least once per month, but less than once per week.

○ Often -- at least once a week.

Q25. Have you ever awakened <u>from a nap</u> and found you were unable to move your whole body and felt paralyzed? *(Please check one)*

- ○ Never.
- ○ Only a few times ever.
- ○ Rarely -- less than once per month.
- ○ Sometimes -- a least once per month, but less than once per week.
- ○ Often -- at least once a week.

Q26. Have you ever awakened <u>during your night's sleep</u> and had the feeling that you could not move your arms and legs, or any part of your body? *(Please check one)*

- ○ Never.
- ○ Only a few times ever.
- ○ Rarely -- less than once per month.
- ○ Sometimes -- a least once per month, but less than once per week.
- ○ Often -- at least once a week.

Q27. When you first wake up after your night's sleep, do you experience any muscle weakness in your hands that makes it hard to firmly grip or squeeze something? *(Note: This does not include the numbness or "pins and needles" feeling from sleeping with too much pressure on your hands or arms.)*

- ○ Never or rarely.
- ○ Sometimes.
- ○ Often -- every day or almost every day.

Q28. Do you have any allergies, like hayfever, that cause nasal congestion, stuffiness, or a runny nose?

- ○ Yes
- ○ No ——→ *If no, skip to Question 31.*

Q29. Do you have the symptoms in:
(Please answer "yes" or "no" for each)

a. Spring?	○	Yes	○	No
b. Summer?	○	Yes	○	No
c. Fall?	○	Yes	○	No
d. Winter?	○	Yes	○	No
e. No specific season?	○	Yes	○	No

Q30. During the times when you have these allergy symptoms, do they occur during the night? *(Please check one)*

- ○ No, only the daytime
- ○ Some nights
- ○ Most nights

Q31. Have you ever been told by a doctor that you have asthma?

- ○ Yes
- ○ No ——→ *If no, skip to Question 35 on page 13.*

Q32. Do you use an inhaler for your asthma? *(Please check one)*

○ **No** ⟶ ***If no, skip to Question 34.***

○ **Sometimes**

○ **Usually**

Q33. What is the brand name or generic name of the inhaler you use for your asthma?

Q34. Do you have asthma attacks during the night? *(Please check one)*

○ **No**

○ **Rarely, less than once a month**

○ **Sometimes, a few times a month**

○ **Often, at least once a week**

Q35. About how many hours per week, if any, do you spend at regular planned exercise (such as jogging, sports, exercise class, workouts at home or in a gym)?

hours per week

Q36. Which of these categories best describes the extent of physical labor your present job demands? *(Please check one)*

○ **High -- main activity of job involves strenuous work (heavy equipment, loading, climbing, etc.)**

○ **Moderate -- main activity of job involves moderate work (standing, reaching, walking, etc.)**

○ **Low -- main job done at desk or sitting with little or no activity.**

○ **Does not apply.**

Q37. What is your age and sex?

Age: Years

Check one: ○ Male

○ Female

Q38. What is your current height without shoes?

Feet Inches

Q39. What is your current weight?

Pounds

Q40. What is your current marital status? *(Please check one)*

- ○ **Married**
- ○ **Separated**
- ○ **Divorced**
- ○ **Widowed**
- ○ **Single, never married**

Thank you very much. Please return the completed survey in the enclosed business-reply envelope to: University of Wisconsin Survey Center, 1180 Observatory Dr. Room 2412, Madison, WI 53791-8266.