

WISCONSIN SLEEP COHORT STUDY

SLEEP AND OUTCOMES QUESTIONNAIRE

This is one of two questionnaires included in this mailed survey (the other is an injury questionnaire). This questionnaire is 9 pages long and has 3 main sections.

1. Sleep habits and problems
2. Diagnosed and medically treated specific health problems
3. General health and well-being

When you have completed this questionnaire and the injury questionnaire, please return them in the included postage-paid addressed envelope along with the signed consent document.

Thank you!



*A population study of sleep
patterns and problems*

1. 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)

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

3. How often, if ever, do you have any of the following problems sleeping?

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)

(Circle one response for each item.)

	Never	Rarely	Some- times	Often	Almost Always
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

4. 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?

5. 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

If the treatment was CPAP or BiPAP:

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

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:

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

If yes: What was the sleep disorder? _____

Do you still have this sleep disorder? ___ Yes ___ No

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

8. Are you satisfied with your **usual** night's sleep (*check one*)? _____ Most of the time
_____ Some of the time
_____ Not usually
_____ Never

9. 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:

The next section asks about specific medical problems. Please indicate if you have been told by a doctor within the last 5 years that you have or have had any of these conditions.

20. Coronary artery disease? ___ Yes ___ No

If yes: Indicate how many years ago _____ or the year _____ you were diagnosed.

Describe what, if any, treatment you received. _____

Have you been told by a doctor within the last 5 years that you have or have had any of these conditions?

21. Atherosclerosis (hardening of the arteries)? ___ Yes ___ No

If yes: Indicate how many years ago _____ or the year _____ you were diagnosed.

Describe what, if any, treatment you received. _____

22. Irregular heartbeat or arrhythmia? ___ Yes ___ No

If yes: Indicate how many years ago _____ or the year _____ you were diagnosed.

Describe what, if any, treatment you received. _____

23. Heart attack or infarct? ___ Yes ___ No

If yes: Indicate how many years ago _____ or the year _____ you were diagnosed.

Describe what, if any, treatment you received. _____

24. Congestive heart failure? ___ Yes ___ No

If yes: Indicate how many years ago _____ or the year _____ you were diagnosed.

Describe what, if any, treatment you received. _____

25. Angina? ___ Yes ___ No

If yes: Indicate how many years ago _____ or the year _____ you were diagnosed.

Describe what, if any, treatment you received. _____

26. Transient Ischemic attack (a TIA or “mini stroke”)? ___ Yes ___ No

If yes: Indicate how many years ago _____ or the year _____ you were diagnosed.

Describe what, if any, treatment you received. _____

Have you been told by a doctor within the last 5 years that you have or have had any of these conditions?

27. Stroke? ___ Yes ___ No

If yes: Indicate how many years ago _____ or the year _____ you were diagnosed.

Describe what, if any, treatment you received. _____

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

If yes: Indicate how many years ago _____ or the year _____ you were diagnosed.

Describe what, if any, treatment you received. _____

29. Diabetes? ___ Yes ___ No

If yes: Indicate how many years ago _____ or the year _____ you were diagnosed.

Describe what, if any, treatment you received. _____

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

If yes: Indicate how many years ago _____ or the year _____ you were diagnosed.

Describe what, if any, treatment you received. _____

31. Thyroid problem? ___ Yes ___ No

If yes: Indicate how many years ago _____ or the year _____ you were diagnosed.

Describe the type of thyroid problem and what, if any, treatment you received. _____

32. Which of the following procedures have you ever had? (check all that apply):

____ Coronary bypass surgery

____ Coronary or balloon angioplasty

____ Insertion of pacemaker or defibrillator

____ Other heart surgery (please describe):

____ None

33. In the past 5 years have you had any major illness or hospitalization? ___ Yes ___ No

If yes: a. When was the *most recent* occurrence? _____ Month/Year

Please describe it:-

b. When was the *next* most recent occurrence? _____ Month/Year ___ NA

Please describe it:-

c. When was the *next* most recent occurrence? _____ Month/Year ___ NA

Please describe it:-

34. Are you currently (*check all that apply*):
- Employed fulltime
 - Employed part time
 - Employed seasonally
 - Fully retired
 - Other

35. What is your current occupation/job title (or previous job if you are now fully retired)?

36. For your job, do you work (*check one*):
- Daytime hours
 - Night shift
 - Rotating shift
 - Other hours, please explain: _____
 - Does not apply

37. Are you currently (*check one*)
- Married
 - Separated
 - Divorced
 - Widowed
 - Single; never married

GENERAL HEALTH AND WELL-BEING

10. In general, would you say your health is (Check one):
- Excellent
 - Very Good
 - Good
 - Fair
 - Poor

11. Compared to one year ago, how would you rate your health in general **now**? (Check one)
- Much better now than 1 year ago
 - Somewhat better now than 1 year ago
 - About the same
 - Somewhat worse now than 1 year ago
 - Much worse now than 1 year ago

12. The following items are about activities you might do during a typical day. Does **your health now limit you** in these activities? If so, how much? (Check one answer on each line.)

Yes, **Yes,** **No, not**
limited a lot limited a little limited at

all

- | | | | |
|---|-------|-------|-------|
| a. <u>Vigorous activities</u> , such as running, lifting heavy objects, participating in strenuous sports. | _____ | _____ | _____ |
| b. <u>Moderate activities</u> , such as moving a table, pushing a vacuum cleaner, bowling, or playing golf. | _____ | _____ | _____ |
| c. Lifting or carrying groceries. | _____ | _____ | _____ |
| d. Climbing <u>several</u> flights of stairs. | _____ | _____ | _____ |
| e. Climbing one flight of stairs. | _____ | _____ | _____ |
| f. Bending, kneeling, or stooping. | _____ | _____ | _____ |
| g. Walking more than a mile. | _____ | _____ | _____ |
| h. Walking <u>several blocks</u> . | _____ | _____ | _____ |
| i. Walking one block. | _____ | _____ | _____ |
| j. Bathing or dressing yourself. | _____ | _____ | _____ |

13. During the **past 4 weeks**, have you had any of the following problems with your work or other regular daily activities **as a result of your physical health**? (Check one answer on each line.)

YES _____

NO _____

- | | | |
|---|-------|-------|
| a. Cut down the amount of time you spent on work or other activities. | _____ | _____ |
| b. Accomplished less than you would like. | _____ | _____ |
| c. Were limited in the kind of work or activities. | _____ | _____ |
| d. Had difficulty performing the work or other activities (e.g., it took extra effort). | _____ | _____ |

12. During the **past 4 weeks**, have you had any of the following problems with your work or other regular daily activities **as a result of any emotional problems** (such as feeling depressed or anxious)? (Check one answer on each line.)

YES _____

NO _____

- | | | |
|---|-------|-------|
| a. Cut down the amount of time you spent on work or other activities. | _____ | _____ |
| b. Accomplished less than you would like. | _____ | _____ |

c. Didn't do work or other activities as carefully as usual. _____

13. During the **past 4 weeks**, to what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbors, or groups? (Check one) _____ Not at all
_____ Slightly
_____ Moderately
_____ Quite a bit
_____ Extremely

14. How much **bodily** pain have you had during the **past 4 weeks**? (Check one) _____ None
_____ Very mild
_____ Mild
_____ Moderate
_____ Severe
_____ Very severe

15. During the **past 4 weeks**, how much did **pain** interfere with your normal work (including both work outside the home and housework)? (Check one) _____ Not at all
_____ Slightly
_____ Moderately
_____ Quite a bit
_____ Extremely

16. These questions are about how you feel and how things have been with you **during the past 4 weeks**.

For each question, please give the one answer that comes closest to the way you have been feeling.

How much of the time during the past 4 weeks... (Check one answer on each line.)

All of the time Most of the time A good bit of the time Some of the time A little of the time None of the time

time

a. Did you feel full of pep? _____

b. Have you been a very nervous person? _____

c. Have you felt so down in the dumps
nothing could cheer you up? _____

d. Have you felt calm and peaceful? _____

e. Did you have a lot of energy? _____

f. Have you felt downhearted and blue? _____

g. Did you feel worn out? _____

h. Have you been a happy person? _____

i. Did you feel tired? _____

17. During the **past 4 weeks**, how much of the time has your **physical or emotional problems** interfered with your social activities (like visiting friends, relatives, etc.)? (Check one)

All of the time
 Most of the time
 Some of the time
 A little of the time
 None of the time

18. Please choose the answer that best describes how **true** or **false** each of the following statements is for you. (Check one answer on each line.)

	Definitely	Mostly	Not	Mostly	Definitely
	<u>True</u>	<u>True</u>	<u>Sure</u>	<u>False</u>	<u>False</u>

a. I seem to get sick a little easier than other people.

b. I am as healthy as anybody I know.

c. I expect my health to get worse.

d. My health is excellent.

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

satisfied

Completely
 Mostly satisfied
 Moderately satisfied
 Not very satisfied