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!

SLEEP
COHORT STUDY
UNIVERSITY OF WISCONSIN-MADISON

A population study of sleep patterns and problems

SLEEP

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 <u>all</u> 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

<u>If yes</u>: **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 <u>all</u> 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

<u>GENERAL HEALTH AND WELL-BEING</u>

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, limited a lot	**Yes, limited a little**	**No, *not* limited at all**
a. Vigorous activities, such as running, lifting heavy objects, participating in strenuous sports.	_____	_____	_____
b. Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf.	_____	_____	_____
c. Lifting or carrying groceries.	_____	_____	_____
d. Climbing several flights of stairs.	_____	_____	_____
e. Climbing one flight of stairs.	_____	_____	_____
f. Bending, kneeling, or stooping.	_____	_____	_____
g. Walking more than a mile.	_____	_____	_____
h. Walking several blocks.	_____	_____	_____
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
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 True	Mostly True	Not Sure	Mostly False	Definitely False
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)?

_____Completely satisfied
_____Mostly satisfied
_____Moderately satisfied
_____Not very satisfied