Approx	CHECK	Variable name (* means there is a comm	Question
1		TIME_ASLEEP	indicate what time you fell asleep last night: _____ Circle AM or PM
2		EVAL_SLEEP	How well did you sleep (check one)? (referring to night before overnight study)
3		TIME_WAKE	What time did you wake up today? _____ Circle AM or PM
4		NAP_TODAY	Did you take any naps today?
5		NAP_TIME	**If yes**, what time did you nap:
6		NAP_LENGTH	How long did you sleep? _____ #minutes
7		EVAL_DAY	How was your day today (check one)?
8		PHYS_PROBS	Do you have any physical problems or discomforts tonight?
9		PHYS_DESC1	**If yes**, indicate what
10		PHYS_DESC2	**If yes**, indicate what
11		PHYS_DESC3	**If yes**, indicate what
12		DRUG_USE	Do you regularly take any medicines?
13		DRUG_OTHER	Have you taken any other kind of drug today?
14		DRUGS_OTHER*	Have you taken any other kind of drug today?
15		DRUGS_OTHER1	what?
16		DRUGS_OTHER2	what?
17		DRUGS_OTHER3	what?
18		SLEEP_AIDS	Do you routinely take any of the following over-the-counter medications? Sleeping aids or s
19		STIMULANTS	Do you routinely take any of the following over-the-counter medications? Stimulants, like M
20		DIETING_AIDS	Do you **routinely** take any of the following over-the-counter medications? Appetite depress
21		CUPS_COFFEE	How many cups of coffee or tea, **with caffeine**, do you usually drink in a typical day?
22		CANS_COLA	How many cans of cola or other soft drinks, **with caffeine**, do you usually drink in a typical
23		COUNTRY_BORN	What country were you born in
24		HERITAGE1	What heritage do you identify most closely with
25		HERITAGE2	What heritage do you identify most closely with
26		TYPE_WORK	What is your current occupation/job title?
27		YEARS_JOB	How many years have you been doing the kind of work you do at your present job?
28		TYPE_SHIFT*	For your job, do you work (check one):
29		TYPE_SHIFT*	For your job, do you work (check one):
30		EMPLOYED_FULLTIME	Are you currently? Employed full time?
31		EMPLOYED_OTHER	Are you currently? Employed full time?
32		EMPLOYED_PARTTIME	Are you currently? Employed part time?
33		EMPLOYED_RETIRED	Are you currently? Retired?
34		EMPLOYED_SEASONALLY	Are you currently? Seasonally?
35		WEIGHT_CONTR	Which category below best fits your experience with weight control (check one)?
36		WEIGHT_20S	Please estimate your weight at the following ages, excluding illness and pregnancy (early 2(
37		WEIGHT_30S	Please estimate your weight at the following ages, excluding illness and pregnancy (early 3(
38		WEIGHT_40S	Please estimate your weight at the following ages, excluding illness and pregnancy (early 4(
39		WEIGHT_50S	Please estimate your weight at the following ages, excluding illness and pregnancy (early 5(
40		BUILD_CHILD	Which of the categories best describes your body build as a child?
41		BUILD_ADOLES	Which of the categories best describes your body build as a teenage?
42		DRIVE	Do you drive a vehicle at least once/week?
43		DRIVE_FREQ	How often you, as the driver, drive to work?
44		DRIVE_MILES	About how many miles is it from your home to your place of work? (one-way)
45		DRIVE_JOB	Do you do any driving as part of your job?
46		DRIVE_JOB_MI	Can you estimate how many miles each week or each year you drive as part of your job?
47		DRIVE_YEAR	Please estimate the total miles per year **you, as the driver**, drive a car. _____ Miles/Ye
48		NASAL_CONG	Have you had any nasal congestion or stuffiness today or tonight?
49		NASAL_CONG1	If yes, do you know what caused the stufiness?
50		NASAL_CONG2	If yes, do you know what caused the stufiness?
51		NASAL_CONG3	If yes, do you know what caused the stufiness?
52		NASAL_NIGHT	Are there times during the year when you experience nasal congestion or stuffiness at nigth
53		NASAL_ALL_YR	If yes, do the periods of stuffiness occur: during specific seasons? OR throughout the year?
54		NASAL_FALL	if seasons, which one? Fall
55		NASAL_SPRING	if seasons, which one? Spring
56		NASAL_SUMMER	if seasons, which one? Summer
57		NASAL_WINTER	if seasons, which one? Winter
58		NASAL_NIGHT1	Do you know what causes the stuffiness?
59		NASAL_NIGHT2	Do you know what causes the stuffiness?
60		NASAL_NIGHT3	Do you know what causes the stuffiness?
61		NASAL_OTHER*	Do you have any other problems, such as an illness, allergy, deviated septum or structural pı
62		NASAL_OTHER1	**If yes**, indicate what (please be specific):

63	NASAL_OTHER2	**If yes**, indicate what (please be specific):
64	NASAL_OTHER3	**If yes**, indicate what (please be specific):
65	NASAL_OTHER4	**If yes**, indicate what (please be specific):
66	NASAL_OTHER5	**If yes**, indicate what (please be specific):
67	ALLERGY_MED	Do you take allergy medicaiton?
68	TYPE_MED1	What do you take?
69	TYPE_MED2	What do you take?
70	TYPE_MED3	What do you take?
71	NASAL_RELIEF	Does it relieve the nasal stuffiness?
72	PAIN	Have you ever had any pain or discomfort in your chest?
73	PAIN_HILL	Do you get it when you walk uphill or hurry?
74	PAIN_PACE	Do you get it when you walk at an ordinary pace on the level?
75	PAIN_ACTION	What do you do if you get it while you are walking?
76	PAIN_TIME	If you stand still, how soon does the pain go away?
77	PAIN_BREASTBONE	Where does the pain occur (check all that apply)? Upper or middle breastbone
78	PAIN_FRONT	Have you ever had a severe pain across the front of your chest lasting for 1/2 hour or more?
79	PAIN_LEFT_ARM	Where does the pain occur (check all that apply)? Left arm
80	PAIN_LEFT_CHEST	Where does the pain occur (check all that apply)? Left side of chest
81	PAIN_LOWER_CHEST	Where does the pain occur (check all that apply)? Lower chest
82	PAIN_OCCURS_OTHER	Where does the pain occur (check all that apply)? Other:
83	PAIN_WHERE51	Where does the pain occur (check all that apply)? Other:
84	PAIN_WHERE52	Where does the pain occur (check all that apply)? Other:
85	PAIN_WHERE53	Where does the pain occur (check all that apply)? Other:
86	PAIN_OTHER	Do you feel it anywhere else?
87	PAIN_OTHER1	If yes, where?
88	PAIN_OTHER2	If yes, where?
89	PAIN_OTHER3	If yes, where?
90	LEG	Do you get pain in either leg on walking? _Y_Yes _N_No
91	LEG_STILL	Does this leg pain ever begin when you are standing still or sitting?
92	LEG_WHERE1	In what part of your leg do you feel it? (2nd mark of other for leg_where1
93	LEG_WHERE2	In what part of your leg do you feel it? (2nd mark of other for leg_where1
94	LEG_WHERE31	In what part of your leg do you feel it? (other code)
95	LEG_WHERE32	In what part of your leg do you feel it? (other code)
96	LEG_WHERE33	In what part of your leg do you feel it? (other code)
97	LEG_HILL	Do you get it if you walk uphill or hurry?
98	LEG_PACE	Do you get it if you walk at an ordinary pace on the level?
99	LEG_DISAPPEAR	Does the pain ever disappear while you are walking? _Y_Yes _N__No
100	LEG_ACTION	What do you usually do if you get it when you are walking?
101	LEG_TIME	If you stand still, how soon does the pain go away?
102	CORONARY_YND	The next section asks about specific medical problems. Please indicate if you have been tolc
103	CORONARY_TX	Also, describe what, if any, treatment you received. (in Coronary artery disease? = "Y")
104	CORONARY_YEAR	If yes, indicate how many years ago ____ or the year ____ you were diagnosed. (if Coronar
105	ATHEROSCL_YND	The next section asks about specific medical problems. Please indicate if you have been tolc
106	ATHEROSCL_TX	Also, describe what, if any, treatment you received. (in Atherosclerosis (hardening of the art
107	ATHEROSCL_YEAR	If yes, indicate how many years ago ____ or the year ____ you were diagnosed. (if Atherosc
108	ARRHYTHMIA_YND	The next section asks about specific medical problems. Please indicate if you have been tolc
109	ARRHYTHMIA_TX	Also, describe what, if any, treatment you received. (in Irregular heartbeat or arrhythmia? =
110	ARRHYTHMIA_YEAR	If yes, indicate how many years ago ____ or the year ____ you were diagnosed. (if Irregular
111	HEARTATTACK_TX	Also, describe what, if any, treatment you received. (in Heart attack or infarct? = "Y")
112	HEARTATTACK_YEAR	If yes, indicate how many years ago ____ or the year ____ you were diagnosed. (if Heart att
113	HEARTATTACK_YND	The next section asks about specific medical problems. Please indicate if you have been tolc
114	CONGESTIVEHF_TX	Also, describe what, if any, treatment you received. (in Congestive heart failure? = "Y")
115	CONGESTIVEHF_YEAR	If yes, indicate how many years ago ____ or the year ____ you were diagnosed. (if Congesti
116	CONGESTIVEHF_YND	The next section asks about specific medical problems. Please indicate if you have been tolc
117	ANGINA_TX	Also, describe what, if any, treatment you received. (in angina = "Y")
118	ANGINA_YEAR	If yes, indicate how many years ago ____ or the year ____ you were diagnosed. (if angina='
119	ANGINA_YND	The next section asks about specific medical problems. Please indicate if you have been tolc
120	CORONARYBYPASS_YND	Have you ever had any of the following surgical procedures? If yes, check all that apply: C
121	ANGIOPLASTY_YND	Have you ever had any of the following surgical procedures? Coronary or balloon angioplas
122	PACEMAKER_YND	Have you ever had any of the following surgical procedures? If yes, check all that apply: In
123	OTHER_HEART_SURGERY_YND	Have you ever had any of the following surgical procedures? If yes, check all that apply: O
124	OTHER_HEART_SURG_CODE1	Have you ever had any of the following surgical procedures? If yes, check all that apply: O
125	OTHER_HEART_SURG_CODE2	Have you ever had any of the following surgical procedures? If yes, check all that apply: O

126		OTHER_HEART_SURG_CODE3	Have you ever had any of the following surgical procedures? If yes, check all that apply: O
127		HYPERTENSION_TX	Also, describe what, if any, treatment you received. (in High blood pressure or hypertension
128		HYPERTENSION_YEAR	If yes, indicate how many years ago ____ or the year ____ you were diagnosed. (if High blo
129		HYPERTENSION_YND	The next section asks about specific medical problems. Please indicate if you have been tol
130		STROKE_TX	Also, describe what, if any, treatment you received. (in stroke?= "Y")
131		STROKE_YEAR	If yes, indicate how many years ago ____ or the year ____ you were diagnosed. (if stroke?=
132		STROKE_YND	The next section asks about specific medical problems. Please indicate if you have been tol
133		DIABETES_TX	Also, describe what, if any, treatment you received. (in Diabetes?= "Y")
134		DIABETES_YEAR	If yes, indicate how many years ago ____ or the year ____ you were diagnosed. (if Diabetes
135		DIABETES_YND	The next section asks about specific medical problems. Please indicate if you have been tol
136		ASTHMA_TX	Also, describe what, if any, treatment you received. (in Asthma? = "Y")
137		ASTHMA_YEAR	If yes, indicate how many years ago ____ or the year ____ you were diagnosed. (if Asthma?
138		ASTHMA_YND	The next section asks about specific medical problems. Please indicate if you have been tol
139		EMPHYSEMA_TX	Also, describe what, if any, treatment you received. (in Emphysema or Obstructive lung disease? =
140		EMPHYSEMA_YEAR	If yes, indicate how many years ago ____ or the year ____ you were diagnosed. (if Enphysema? ="
141		EMPHYSEMA_YND	The next section asks about specific medical problems. Please indicate if you have been told by a d
142		THYROID_TX	Also, describe what, if any, treatment you received. (in thyroid problem = "Y")
143		THYROID_YEAR	If yes, indicate how many years ago ____ or the year ____ you were diagnosed. (if Thyroid
144		THYROID_YND	The next section asks about specific medical problems. Please indicate if you have been tol
145		THYROID_PROBLEM_CODE	Also, describe the type of thyroid problem and what, if any, treatment you received. (in thyr
146		EPILEPSY_TX	Also, describe what, if any, treatment you received. (in Epilepsy or convulsions? = "Y")
147		EPILEPSY_YEAR	If yes, indicate how many years ago ____ or the year ____ you were diagnosed. (if Epilepsy
148		EPILEPSY_YND	The next section asks about specific medical problems. Please indicate if you have been tol
149		ARTHRITIS_TX	Also, describe what, if any, treatment you received. (in Arthritis? = "Y")
150		ARTHRITIS_YEAR	If yes, indicate how many years ago ____ or the year ____ you were diagnosed. (if Arthritis
151		ARTHRITIS_YND	The next section asks about specific medical problems. Please indicate if you have been tol
152		BACK_PAIN*	Have you had any <u>chronic</u> joint or back pain?
153		BACK_YEAR1	**If yes**, when did it occur? _____ Month/Year (if any chronic joint or back pain="Y")
154		BACK_YEAR2	**If yes**, when did it occur? _____ Month/Year (if any chronic joint or back pain="Y")
155		BACK_CODE1	Please describe it: (if any chronic joint or back pain="Y")
156		BACK_CODE2	Please describe it: (if any chronic joint or back pain="Y")
157		ILLNESS*	have you had any <u>major</u> illness or hospitalization?
158		ILL_YEAR1	**If yes**, when did it occur? _____ Month/Year
159		ILL_YEAR2	**If yes**, when did it occur? _____ Month/Year
160		ILL_CODE1	Please describe it:
161		ILL_CODE2	Please describe it:
162	**don't' kn	DENTAL_WORK*	Have you ever had any dental work, like braces, retainers, or dentures to change your bite o
163		DENTAL_DESC1	What (any dental work, like braces or retainers, to change your bite or your jaw position?)
164		DENTAL_DESC2	What (any dental work, like braces or retainers, to change your bite or your jaw position?)
165		DENTAL_AGE1	How old were you when this work was done?
166		DENTAL_AGE2	How old were you when this work was done?
167		DENTAL_YEAR1	When was the work done? _____ Month/Year
168		DENTAL_YEAR2	When was the work done? _____ Month/Year
169		INJ_SURGERY*	have you had an injury to or surgery on your nose or face? ___Yes ___No
170		INJ_DESC1	Please describe it:
171		INJ_DESC2	Please describe it:
172		INJ_DESC3	Please describe it:
173		INJ_DESC4	Please describe it:
174		INJ_DESC5	Please describe it:
175		INJ_YEAR1	When was the work done? _____ Month/Year
176		INJ_YEAR2	When was the work done? _____ Month/Year
177		INJ_YEAR3	When was the work done? _____ Month/Year
178		INJ_YEAR4	When was the work done? _____ Month/Year
179		INJ_YEAR5	When was the work done? _____ Month/Year
180		TONSILS	Have you had your tonsils removed?
181		TONSILS_AGE	How old were you then? (when tonsils were removed)
182		TONSILS_YEAR	If yes (to tonsils removed question), when was the surgery performed?
183		Adenoids	Have you had your adenoids removed?
184		ADENOIDS_AGE	How old were you then? (when adenoids were removed)
185		ADENOIDS_YEAR	If yes (to adenoids removed question), when was the surgery performed?
186		DROWN_GAS	Have you ever had any of these experiences? Been partially drowned or overcome by a toxi
187		UNCONSCIOUS	Have you ever had any of these experiences? Been unconscious or in a coma?
188		HEAD_INJURY	Have you ever had any of these experiences? Had a head injury?
189		BEER_WEEK*	Please estimate your **usual** consumption of alcoholic beverages,How many cans or bottles o

190	WINE_WEEK	Please estimate your **usual** consumption of alcoholic beverages,How many glasses of wine
191	HARD_WEEK	Please estimate your **usual** consumption of alcoholic beverages,How many mixed drinks or
192	NONDRINKER	If you do not drink alcoholic beverages at all check here ____
193	NON_PAST5Y*	If non-drinker, ask: Thinking back over the past fie yers, did you drink alcoholic beverages
194	NON_NUMBER	If Yes, about how many beers or drinks containing alcohol might you have had in a typical v
195	DRINK_NIGHTS	How many nights, during a typical week, might you have an alcoholic drink within 1 hour o
196	DRINK_PAST5Y	your current amount of drinking fairly typical of your habits over the last 5 years?
197	DRINK_PAST	**If no**, how is your drinking different from the past (*check <u>one</u>*)?
198 need date	DRINK_24HRS*	Have you had any alcoholic beverages today? ___Yes ___No
199	DRINK_NUMBER	How many? _____ # of drinks
200	DRINK_TIME	At about what time was that
201	SMOKE	Have you ever smoked tobacco regularly?
202	SMOKE_CURR	Do you currently smoke?
203	SMOKE_QUIT	**If no**, when did you quit?
204	SMOKE_QUIT_YEARS_AGO	
205	SMOKE_YEARS	Overall, how many years total, have you been **OR** were you a regular smoker?
206	BOWLS_DAY	How much do you smoke now, OR if you quit smoking, how much did you smoke in the pa
207	PACKS_WEEK	How much do you smoke now, OR if you quit smoking, how much did you smoke in the pa
208	CIGARS_DAY	How much do you smoke now, OR if you quit smoking, how much did you smoke in the pa
209	FATIGUED	Do you **usually** feel tired or fatigued at times **<u>during a typical day</u>**? ___Yes ___No
210	FATIGUE_CONCENTRATE	**<u>If yes</u>**<u>, does the tiredness interfere with your (*check all that apply*):Ability to concentrate</u>
211	FATIGUE_ENJOYMENT_OF_L	**<u>If yes</u>**<u>, does the tiredness interfere with your (*check all that apply*):Enjoyment of life</u>
212	FATIGUE_HOUSEWORK	**<u>If yes</u>**<u>, does the tiredness interfere with your (*check all that apply*):Housework</u>
213	FATIGUE_MOOD	**<u>If yes</u>**<u>, does the tiredness interfere with your (*check all that apply*):Mood</u>
214	FATIGUE_MOTIVATION	**<u>If yes</u>**<u>, does the tiredness interfere with your (*check all that apply*):Motivation</u>
215	FATIGUE_NONE	**<u>If yes</u>**<u>, does the tiredness interfere with your (*check all that apply*):None of the above, tiredn</u>
216	FATIGUE_OTHER	**<u>If yes</u>**<u>, does the tiredness interfere with your (*check all that apply*):Other</u>
217	FATIGUE_RELATIONSHIPS	**<u>If yes</u>**<u>, does the tiredness interfere with your (*check all that apply*):Relationships with peopl</u>
218	FATIGUE_WORK	**<u>If yes</u>**<u>, does the tiredness interfere with your (*check all that apply*):Work</u>
219	SLEEPINESS	Many people have periods of low energy or fatigue, but, **<u>during a typical day</u>** do you exper
220	SLEEPINESS_WORK	**If yes**, does the tiredness interfere with your (*check <u>all</u> that apply*): Work
221	SLEEPINESS_MOOD	**If yes**, does the tiredness interfere with your (*check <u>all</u> that apply*): Mood
222	SLEEPINESS_RELATIONSHIPS	**If yes**, does the tiredness interfere with your (*check <u>all</u> that apply*): relationships with peopl
223	SLEEPINESS_ENJOYMENT_OF_LIFE	**If yes**, does the tiredness interfere with your (*check <u>all</u> that apply*): enjoyment of life
224	SLEEPINESS_CONCENTRATE	**If yes**, does the tiredness interfere with your (*check <u>all</u> that apply*): ability to concentrate
225	SLEEPINESS_MOTIVATION	**If yes**, does the tiredness interfere with your (*check <u>all</u> that apply*): Motivation
226	SLEEPINESS_HOUSEWORK	**If yes**, does the tiredness interfere with your (*check <u>all</u> that apply*): Housework
227	SLEEPINESS_OTHER	**If yes**, does the tiredness interfere with your (*check <u>all</u> that apply*): Other
228	SLEEPINESS_NONE	None of the above, tiredness does not interfer with my activities
229	SLEEPINESS_WORKDAY_MOR	**If yes,** when it is difficult to fight the urge to fall asleep?
230	SLEEPINESS_WORKDAY_AFT	**If yes,** when it is difficult to fight the urge to fall asleep?
231	SLEEPINESS_EVENINGS	**If yes,** when it is difficult to fight the urge to fall asleep?
232	SLEEPINESS_WEEKEND_MOR	**If yes,** when it is difficult to fight the urge to fall asleep?
233	SLEEPINESS_WEEKEND_AFT	**If yes,** when it is difficult to fight the urge to fall asleep?
234	SLEEPINESS_WEEKEND_EVE	**If yes,** when it is difficult to fight the urge to fall asleep?
235	SLEEPINESS_NO_CERTAIN_	**If yes,** when it is difficult to fight the urge to fall asleep?
236	SLEEP_WHY	Do you know why you have periods of sleepiness?
237	SLEEP_REAS1	**If yes**, what is the reason(s)?
238	SLEEP_REAS2	**If yes**, what is the reason(s)?
239	SLEEP_REAS3	**If yes**, what is the reason(s)?
240	SLEEP_REAS4	**If yes**, what is the reason(s)?
241	NAP_FREQ	How often, **on average**, do you take a nap during the day or the evening (*check one*)?
242	SNORE_FREQ	According to what other have told you or to your own awareness, how often do you snore?
243	SNORE_VOL	How loud do you think, or have others said, your snoring is?
244	CHOKE_FREQ	According to what others have told you, or to your own awareness, how often, if ever, do yc
245	AWAKE_FREQ	How often, if ever, have you awakened suddenly with the feeling of gasping or choking?
246	AWAKE_FREQ*	How often, if ever, have you awakened suddenly with the feeling of gasping or choking?
247	APNEA_FREQ*	According to what others have told you, or to your own awareness, how often, if ever, do yc
248	APNEA_FREQ*	According to what others have told you, or to your own awareness, how often, if ever, do yc
249	KICK_FREQ	According to what others have told you, how often, if ever, do you kick or make other disru
250	WORKDAY	How many hours of sleep do you usually get during: workday night
251	WEEKEND	How many hours of sleep do you usually get during: a weekend or non worknight
252	NAPS	How many hours of sleep do you usually get during: a typical week from daytime or evenin

253	TSO	About how many minutes does it **usually** take you to fall asleep at night? _____#minutes
254	PS_DIFF	How often, if ever, do you have any of the following problems sleeping? (Circle one respon
255	PS_BACKSLEEP	How often, if ever, do you have any of the following problems sleeping? (Circle one respon
256	PS_WAKEREPEAT	How often, if ever, do you have any of the following problems sleeping? (Circle one respon
257	PS_TOOEARLY	How often, if ever, do you have any of the following problems sleeping? (Circle one respon
258	PS_NOTRESTED	How often, if ever, do you have any of the following problems sleeping? (Circle one respon
259	PS_WAKEUP	How often, if ever, do you have any of the following problems sleeping? (Circle one respon
260	PS_NIGHTMARE	How often, if ever, do you have any of the following problems sleeping? (Circle one respon
261	PS_EDS	How often, if ever, do you have any of the following problems sleeping? (Circle one respon
262	PS_WEAK	How often, if ever, do you have any of the following problems sleeping? (Circle one respon
263	PS_MOVE	How often, if ever, do you have any of the following problems sleeping? (Circle one respon
264	PS_MOVESLEEP	How often, if ever, do you have any of the following problems sleeping? (Circle one respon
265	SLEEP_PROB	Have you ever **gone to a doctor** for any **sleep problem**?
266	PROB_DATE	**If yes**, please indicate when _____(Month/Year)
267	PROB_DOC1	What kind of doctor (general, family, sleep medicine, etc.) did you see?
268	PROB_DOC2	What kind of doctor (general, family, sleep medicine, etc.) did you see?
269	PROB_DOC3	What kind of doctor (general, family, sleep medicine, etc.) did you see?
270	PROB_TEST1	What, tests, if any, were done?
271	PROB_TEST2	What, tests, if any, were done?
272	PROB_TEST3	What, tests, if any, were done?
273	PROB_STUDY	Did you see a doctor due to the results of your last sleep study in our lab?
274	PROB_CODE1	What sleep problem(s) were you trying to get help for?
275	PROB_CODE2	What sleep problem(s) were you trying to get help for?
276	PROB_CODE3	What sleep problem(s) were you trying to get help for?
277	APNEA	Have you ever been **told by a doctor** that you have **sleep apnea**?
278	APNEA_DATE	**If yes**, when was this? _____ Month/Year (reported Y told by a doctor that they had slee
279	APNEA_TEST1	What tests, if any, were done? (reported Y told by a doctor that they had sleep apnea)
280	APNEA_TEST2	What tests, if any, were done? (reported Y told by a doctor that they had sleep apnea)
281	APNEA_TEST3	What tests, if any, were done? (reported Y told by a doctor that they had sleep apnea)
282	APNEA_NEED	Were you told you needed treatment? ___Yes ___No (reported Y told by a doctor that th
283	APNEA_TREAT1	**If yes**, what treatment was recommended? (When told "Y" need treatment for sleep apnea)
284	APNEA_TREAT2	**If yes**, what treatment was recommended? (When told "Y" need treatment for sleep apnea)
285	APNEA_TREAT3	**If yes**, what treatment was recommended? (When told "Y" need treatment for sleep apnea)
286	APNEA_TREATED	Did you have the treatment? (when told "Y" needed treatment for sleep apnea
287	TREATMENT_DATE	**If yes**, when did you first have the treatment? _____ Month/Year
288	TREATMENT_HELP	Did the treatment help (*check one*)?
289	TREAT_COM1	Comments:
290	TREAT_COM2	Comments:
291	TREAT_COM3	Comments:
292	NONCOMP1	If the treatment was CPAP or BiPAP please answer the following questions: If you are not u
293	NONCOMP2	If the treatment was CPAP or BiPAP please answer the following questions: If you are not u
294	NONCOMP3	If the treatment was CPAP or BiPAP please answer the following questions: If you are not u
295	COMP_HRNIGHT	If the treatment was CPAP or BiPAP please answer the following questions:: If you are usin
296	COMP_NIGHTS_WK	If the treatment was CPAP or BiPAP please answer the following questions:: If you are usin
297	COMP_PROB1	If the treatment was CPAP or BiPAP please answer the following questions: Describe the pr
298	COMP_PROB2	If the treatment was CPAP or BiPAP please answer the following questions: Describe the pr
299	COMP_PROB3	If the treatment was CPAP or BiPAP please answer the following questions: Describe the pr
300	NARCO	Have you ever been **told by a doctor** that you have **narcolepsy**?
301	NARCO_DATE	**If yes**, when was this? _____ Month/Year
302	NARCO_TEST1	What tests, if any, were done?
303	NARCO_TEST2	What tests, if any, were done?
304	NARCO_TEST3	What tests, if any, were done?
305	NARCO_NEED	Were you told you needed treatment?
306	NARCO_TREAT1	**If yes**, what treatment was recommended?
307	NARCO_TREAT2	**If yes**, what treatment was recommended?
308	NARCO_TREAT3	**If yes**, what treatment was recommended?
309	NARCO_TREATED	Did you have the treatment?
310	N_TREAT_DATE	If yes, when did you first have the treatment? (for narcolopsy)
311	N_TREAT_HELP	Did the treatment help (check one)? (for narcolepsy)
312	N_TREAT_COM1	Comments:(on treatment for narcolepsy)
313	N_TREAT_COM2	Comments:(on treatment for narcolepsy)
314	N_TREAT_COM3	Comments:(on treatment for narcolepsy)
315	SD	Have you ever been **told by a doctor** that you had any **other sleep disorder**?

316	SD_CODE1	**If yes**, what sleep disorder were you told you had?
317	SD_CODE2	**If yes**, what sleep disorder were you told you had?
318	SD_CODE3	**If yes**, what sleep disorder were you told you had?
319	SD_DATE	When was this? ___ Month/Year
320	SD_TEST1	What tests, if any, were done?
321	SD_TEST2	What tests, if any, were done?
322	SD_TEST3	What tests, if any, were done?
323	SD_NEED	Were you told you needed treatment?
324	SD_TREAT1	**If yes**, what treatment was recommended?
325	SD_TREAT2	**If yes**, what treatment was recommended?
326	SD_TREAT3	**If yes**, what treatment was recommended?
327	SD_TREATED	Did you have the treatment?
328	SD_TREAT_DATE	**If yes**, when did you first have the treatment? _____ Month/Year
329	SD_TREAT_HELP	Did the treatment help (*check one*)?
330	SD_TREAT_COM1	Comments:
331	SD_TREAT_COM2	Comments:
332	SD_TREAT_COM3	Comments:
333	OTHER	Other than what you have described above, have you ever tried to get medical care for a sle
334	OTHER_DATE	**If yes**, when was this? _____ Month/Year
335	OTHER_HELP1	What was the problem(s) you were trying to get help for?
336	OTHER_HELP2	What was the problem(s) you were trying to get help for?
337	OTHER_HELP3	What was the problem(s) you were trying to get help for?
338	OTHER_DOC1	What kind of doctor (general, family, sleep medicine, etc.) did you contact
339	OTHER_DOC2	What kind of doctor (general, family, sleep medicine, etc.) did you contact
340	OTHER_DOC3	What kind of doctor (general, family, sleep medicine, etc.) did you contact
341	OTHER_COM1	What did the doctor tell you?
342	OTHER_COM2	What did the doctor tell you?
343	OTHER_COM3	What did the doctor tell you?
344	BROTHERS	How many brothers and sisters do you have? Brothers?
345	SISTERS	How many brothers and sisters do you have? Sisters?
346	CHILDREN	Do you have any children?
347	PREGNANCIES*	How many pregnancies have you had?
348	MEN_SURGERY*	Have you had surgery that caused your enstrual periods to stop permanently?
349	MEN_IRREG*	not used
350	MEN_IRREGTMP*	Do you have irregular periods?
351	MEN_REGULAR*	Do you have fairly regular periods?
352	MEN_STOP_MO*	Can you estimate when your last period was or how old you were when you had your last pe
353	MEN_STOP_YR*	Can you estimate when your last period was or how old you were when you had your last pe
354	NO_PERIODS	not used
355	BRTH_CNTL*	Do you currently take birth control pills?
356	HORMON_SUPPL*	Do you take supplemental hormones for menopause?
357	HORMON_YEARS*	How many years did you take them?
358	EVAL_GENERAL	Are you satisfied with your **usual** night's sleep (*check one*)?
359	COMMENT1	If there are any comments you would like to make about the quality of your sleep, or getting
360	COMMENT2	If there are any comments you would like to make about the quality of your sleep, or getting
361	COMMENT3	If there are any comments you would like to make about the quality of your sleep, or getting
362	EVAL_HEALTH	In general, would you say your health is (*check one*):
363	EVAL_LIFE	How satisfied are you with the way you are spending your life (*check one*)?