

**The first set of questions are about your health at any time over the last 12 months.**

1. Have you had wheezing or whistling in your chest? (✓ one)    \_\_\_ Yes    \_\_\_ No
2. Have you ever woken up with a feeling of tightness in your chest first thing in the morning? (✓ one)  
\_\_\_ Yes    \_\_\_ No
3. Have you had an *attack* of shortness of breath that came on during the day when you were not doing anything strenuous? (✓ one)  
\_\_\_ Yes    \_\_\_ No
4. Have you had an *attack* of shortness of breath that came on after you stopped exercising? (✓ one)  
\_\_\_ Yes    \_\_\_ No
5. Have you been awakened at night by an attack of shortness of breath? (✓ one)    \_\_\_ Yes    \_\_\_ No
6. Have you been awakened at night by an attack of coughing? (✓ one)    \_\_\_ Yes    \_\_\_ No

**The following questions concern your asthma symptoms.**

7. Have you ever been *told by a doctor* that you have asthma? (✓ one)  
\_\_\_ Yes    \_\_\_ No (If no, stop here. You do not need to complete the rest of this form)  
If yes, when were you first told by your doctor that you have asthma? \_\_\_\_\_ (Month/Year)
8. How much does your asthma bother you at night? (✓ one)  
\_\_\_\_\_ Never.  
\_\_\_\_\_ Rarely - only a few times ever.  
\_\_\_\_\_ Sometimes - a few nights per month.  
\_\_\_\_\_ Several (3 to 5) nights per week.  
\_\_\_\_\_ Every night or almost every night.
9. When you have asthma symptoms at night, do you have problems with any of the following? (✓ all that apply)  
\_\_\_\_\_ Coughing.  
\_\_\_\_\_ Wheezing.  
\_\_\_\_\_ Chest congestion.  
\_\_\_\_\_ Asthma attack with problem breathing.  
\_\_\_\_\_ Other symptoms. (Please describe: \_\_\_\_\_)

10. How many asthma attacks have you had over the last 6 months? (If none, enter 0) \_\_\_\_\_ #attacks

11. Over the past 6 months, how many nights have you had problems with asthma or asthma attacks?

(If none, enter 0) \_\_\_\_\_ #nights

12. On nights when you have a problem with asthma, how many times do you usually wake up?

(If none, enter 0) \_\_\_\_\_ #times

13. Do you ever have asthma symptoms when you wake up in the morning? (✓ one)

\_\_\_\_\_ Never.

\_\_\_\_\_ Rarely - only a few times ever.

\_\_\_\_\_ Sometimes - a few nights per month.

\_\_\_\_\_ Several (3 to 5) nights per week.

\_\_\_\_\_ Every night or almost every night.

14. When does your asthma bother you more? (✓ one) \_\_\_ Day or \_\_\_ Night

15. How severe is your asthma? (✓ one)

\_\_\_ Very mild.

\_\_\_ Mild.

\_\_\_ Moderate.

\_\_\_ Severe.

\_\_\_ Very severe.

16. Please list the name of each drug you take for asthma:

a. \_\_\_\_\_

e. \_\_\_\_\_

b. \_\_\_\_\_

f. \_\_\_\_\_

c. \_\_\_\_\_

g. \_\_\_\_\_

d. \_\_\_\_\_

h. \_\_\_\_\_

Please return your completed questionnaire and diary in the self-addressed stamped envelope we have provided. Thank you for your time and cooperation. Your participation in this part of our Sleep Cohort Study is greatly appreciated.