

# Survey 1 v2

## Sleep Survey

1. Have you ever been told that you snore?  
1 Yes     2 No: Skip to Question 7, Below.
2. Have any of these people told you that you snore?
  - a. Someone sleeping in the same bedroom?    1 Yes    2 No
  - b. Someone sleeping in other rooms?    1 Yes    2 No
  - c. Persons who have been awake while you sleep or nap somewhere (sofa, car, etc.)?    1 Yes    2 No
3. According to what others have told you, please estimate how often you snore (CHECK ONE)
  1. Rarely — only once or a few times ever.
  2. Sometimes — a few nights per month; under special circumstances.
  3. At least once a week, but pattern may be irregular.
  4. Several nights (3 to 5) per week.
  5. Every night or almost every night.
  7. Do not know.
4. How loud have others said your snoring is? (CHECK ONE)
  1. Only slightly louder than heavy breathing.
  2. About as loud as mumbling or talking
  3. Louder than talking
  4. Extremely loud — can be heard through a closed door.
  7. Do not know.
5. Has anyone who shared your bedroom ever moved, either temporarily or permanently, to another bedroom (or had you move to another bedroom) due to your snoring?  
1 Yes    2 No
6. Based on what others have told you, about how many years do you think you have been snoring?  
Number of years: \_\_\_\_    7 Do not know.
7. Aside from what others may have told you, how often—if ever—have you had the feeling or awareness that you have been snoring?
  1. Never.
  2. Rarely—only once or a few times ever.
  3. Sometimes—a few nights per month.
  4. Often—at least once a week, but pattern may be irregular.
  5. Very often—every night or almost every night.
  7. Not sure.
8. According to what others have told you, how often—if ever— do you gasp, choke, or make snorting sounds during sleep?
  1. Never
  2. Rarely—only once or a few times ever.
  3. Sometimes—a few nights per month.
  4. Often—at least once a week, but pattern may be irregular.
  5. Very often—every night or almost every night.
  7. Do not know.
9. How often—if ever—have you wakened suddenly with the feeling of gasping or choking?

1. Never
2. Rarely—only once or a few times ever.
3. Sometimes—a few nights per month.
4. Often—at least once a week, but pattern may be irregular.
5. Very often—every night or almost every night.
7. Not sure.

10. 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?

1. Never
2. Rarely—only once or a few times ever.
3. Sometimes—a few nights per month.
4. Often—at least once a week, but pattern may be irregular.
5. Very often—every night or almost every night.
7. Not sure.

11. According to what others have told you, how often—if ever do you kick or make other disruptive movements during sleep?

1. Never  
(SKIP TO QUESTION 13)
2. Rarely
3. Sometimes
4. Often
5. Very often
7. Not sure.

12. Has anyone who shared your bedroom ever moved to another bedroom (or had you move to another bedroom because of your kicking or disruptive sleep movements)?

1 Yes    2 No

13. Please check if you never, rarely, sometimes, often, or almost always have each of these sleeping problems. (CHECK FOR EACH PROBLEM)

Never (0)	Rarely (1/mo)	Sometimes (2-4/mo)	Often (5-15/mo)	Almost Always (16- 30/mo)	Sleeping Problems
					a. Difficulty in getting to sleep.
					b. Wake up during 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 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. Fall asleep or doze momentarily—watching TV, reading, etc.
					n. Fall asleep or doze momentarily—at meetings, church, etc.
					o. Need for coffee or other stimulants to stay awake during the day.

14. Approximately how many minutes does it usually take you to fall asleep?

# minutes: \_\_\_\_\_

15. How many hours of sleep do you usually get in ....

a. a workday night? # of hours: \_\_\_\_\_

b. a weekend or non-work night? # of hours: \_\_\_\_\_

c. How many hours of sleep do you usually get in a typical week from daytime or evening **naps**?

0. None, or #hours/week: \_\_\_\_\_

16. Please check whether or not you have been told by a physician that you had or have each condition listed below.

<b>Told by physician?</b>	<b>Condition</b>
1 Yes    2 No	a. Sleep apnea (condition where breathing stops momentarily during sleep.)
1 Yes    2 No	b. Narcolepsy (inability to stay awake)
1 Yes    2 No	c. Asthma
1 Yes    2 No	d. Emphysema
1 Yes    2 No	e. Chronic bronchitis
1 Yes    2 No	f. Angina
1 Yes    2 No	g. Coronary heart disease or hardening of the arteries
1 Yes    2 No	h. Heart attack
1 Yes    2 No	i. Stroke
1 Yes    2 No	j. Hypertension or high blood pressure

17. What was your last blood pressure reading and in about what month and year was it last taken?

Blood pressure: \_\_\_\_\_ over \_\_\_\_\_    7 Do not know.

Taken in Month: \_\_\_\_\_, 19 \_\_\_\_\_    7 Do not know.

18. Were you taking any medication to control your blood pressure at the time it was last taken?

1 Yes    2 No    7 Do not know.

19. Do you have any allergies, like hayfever, that cause nasal congestion, and if so, do you take medication for them?

1. Yes, I have allergies and take medication.
2. Yes, I have allergies, but do not take medication.
3. No, do not have allergies

20. Has your mother or your father ever been diagnosed as having one or both of these conditions? (PLEASE CHECK FOR BOTH PARENTS)

Mother			Father			Condition
Yes	No	Don't know	Yes	No	Don't know	
						a. Narcolepsy (inability to stay awake).
						b. Sleep apnea (condition where breathing stops momentarily during sleep).

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21. A few background questions remain that will help us interpret the results of the research. First, do you currently smoke cigarettes?

1 Yes (SKIP TO QUESTION 21b.) 2 No

21a. Have you ever been a regular smoker, (that is, smoked at least a pack a week)?

1 Yes 2 No: Skip to Question 22

21b. How many years total have you been a regular smoker? #of years: \_\_\_\_\_

21c. About how much do you (or did you) smoke? # of packs of cigarettes per week: \_\_\_\_\_

22. Please record your usual working hours for the category that best fits your job. (If you work alternating shifts, complete all categories that apply.)

a. Daytime job: \_\_\_\_\_ AM to \_\_\_\_\_ PM

b. Afternoon job: \_\_\_\_\_ AM to \_\_\_\_\_ PM

c. Nighttime job: \_\_\_\_\_ AM to \_\_\_\_\_ PM

23. What is your age and sex? Age: \_\_\_\_\_ 1 Male 2 Female

24. What is your height without shoes? \_\_\_\_\_ ft. \_\_\_\_\_ in.

25. What is your present weight? \_\_\_\_\_

26. Excluding times of illness or pregnancy, what has the range of your weight been over the past five years?

Least weight: \_\_\_\_\_ #lbs. Most weight: \_\_\_\_\_ #lbs

27. Are you currently...

1. Married

2. Separated

3. Divorced

4. Widowed

5. Single; never married

28. Please list the ages of your children—if any.

0 No children, or (Ages:) \_\_\_\_\_; \_\_\_\_\_; \_\_\_\_\_; \_\_\_\_\_; \_\_\_\_\_; \_\_\_\_\_; \_\_\_\_\_

29. What is the highest level of formal school you completed?

1. 8th grade or less

2. 9th to 11th grade
3. 12th grade/high school graduate
4. Some college
5. Bachelor's degree from college
6. Post graduate work in college

30. Are you also a technical/vocational school graduate?      1 Yes      2 No

31. 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 a gym)?      # hours/week: \_\_\_\_\_

32. Which one of these categories best describes the extent of physical labor your present job demands?  
(CHECK ONE)

1. High—main activity of job involves strenuous work (heavy equipment, loading, climbing, etc.)
2. Moderate—main activity of job involves moderate work (standing, reaching, walking, etc.)
3. Low—main job done at desk or sitting with little or no activity.

THANK YOU VERY MUCH. PLEASE RETURN THE COMPLETED QUESTIONNAIRE IN THE STAMPED ENVELOPE PROVIDED TO: THE UNIVERSITY OF WISCONSIN-EXTENSION, WISCONSIN SURVEY RESEARCH LABORATORY, 610 LANGDON STREET (109 LOWELL HALL), MADISON, WI 53703