Appendices

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Quick Links to Population-Based Studies

The appendices contain selected images of the surveys and questionnaires cited in the main body of this document to give one an idea of the design and content of the survey and/or questionnaire. The reader is directed to Appendix IV for quick links to the Internet where the Population-Based Studies questionnaires, and Questions from the Large-Sample Sleep Studies, and Sleep Scales can be directly accessed.

For more information, contact:

National Center on Sleep Disorders Research
National Heart, Lung, and Blood Institute, Division of Lung Diseases
National Institutes of Health
6701 Rockledge Drive, 10th Floor
Bethesda, MD 20892

Phone/Fax:
301-435-0199 (phone)
301-480-3451 (fax)
NCSDR E-mail

Appendix I.
Relevant Questions From National Studies

Table of Contents

A. American Time Use Survey Questionnaire, 2004 ..... I–5
B. Behavioral Risk Factor Surveillance System State Questionnaire I–6
C. CDC Pregnancy Risk Assessment Monitoring System 1999 Surveillance Report I–8
D. Fatality Analysis Reporting System I–8
E. Framingham Heart Study I–8
F. Global School-Based Survey 2004 Core Questionnaire I–10
G. National Asthma Survey, 2003 ..... I–10
H. National Comorbidity Survey, 1990–1992 ..... I–10
I. National Health Interview Survey, 2002 ..... I–12
J. National Health and Nutrition Examination Survey I–15
K. National Household Survey on Drug Abuse I–17
L. National Sleep Foundation, Sleep in America Poll I–21
M. National Survey of Children's Health, 2003 ..... I–42
N. National Survey of Early Childhood Health I–42
O. Nurses' Health Study I–43
P. United Nations General Social Survey, Cycle 12: Time Use I–43
Q. U.S. Department of Labor, Bureau of Labor Statistics: National Longitudinal Survey I–44
R. Department of Veterans Affairs Databases I–45
S. National Hospital Discharge Survey I–45
T. National Vital Statistics System I–45
U. Women's Health Initiative I–46
V. Sleep Heart Health Study (SHHS) I–50
W. National Ambulatory Medical Care Survey I–53

A. American Time Use Survey Questionnaire, 2004

Relevant Questions:

The amount of sleep can be derived by examining the following sequence of questions regarding response #1 (Sleeping). Note that "DP" refers to the Designated Person in a sampled household who is providing information about him- or herself.

Section 4: Diary

ACTIVITY
Universe: **All**

So let's begin. Yesterday, [previous weekday] at 4:00 AM, what were you doing? /What did you do next?
*Use the slash key (/) for recording separate/simultaneous activities.

1. Sleeping
2. Grooming (self)
3. Watching TV
4. Working at main job
5. Working at other job
6. Preparing meals or snacks
7. Eating and drinking
8. Cleaning kitchen
9. Laundry
10. Grocery shopping
11. Attending religious service
12. Paying household bills
13. Caring for animals and pets [Go to TIME]

30. Don't know/ Can't remember
31. Refusal/ None of your business

TIME
Universe: **ACTIVITY = valid response**

How long did you spend [ACTIVITY]?

1. Enter duration (hours, minutes). [Go to HOURDUR]
2. Enter stop time. [Go to STOPTIME]

HOURDUR
Universe: **Activity = valid response**

Enter Hours [Go to MINDUR]

MINDUR
Universe: **All**

Enter Minutes [Go to STOPTIME]

STOPTIME
Universe: **All**

Enter AM or PM

WHO
Universe: ACTIVITY ≠ 1, 2, 4, 5, 30, 31

Who was with you? / Who accompanied you?
0. Alone
1. -39. Household members and non-household children
50. All household members
51. Parents
52. Other non-HH family members
53. Other non-HH family members
54. Friends
55. Co-workers, colleagues, clients
56. Neighbors, acquaintances
57. Other non-HH children < 18
58. Other non-HH adults 18 and older [Go to WHERE]

WHERE
Universe: ACTIVITY ≠ 1, 2, 30, 31

Where were you while you were [ACTIVITY]?

PLACE		MODE OF TRANSPORTATION
1. DP's home or yard	30. Bank	12. Car, truck, or motorcycle (driver)
2. DP's workplace	31. Gym/ Health Club	13. Car, truck, or motorcycle (passenger)
3. Someone else's home	32. Post Office	14. Walking
4. Restaurant/Bar		15. Bus
5. Place of worship		16. Subway/Train
6. Grocery store		17. Bicycle
7. Other store/Mall		18. Boat/Ferry
8. School		19. Taxi/Limousine Service
9. Outdoors away from home		20. Airplane
10. Library		21. Other (specify)
11. Other place (specify)	[If STOPTIME > 4 AM, go to next section] [Else continue to next row]	

B. Behavioral Risk Factor Surveillance System State Questionnaire

Relevant Questions:

Module 7: Quality of Life

9. During the past 30 days, for about how many days have you felt you did not get enough rest or sleep? (243-244)

a. Number of days . . . . . __ __

b. None 8 8

Don't know/Not sure 7 7

Refused 9 9

Behavioral Risk Factor Questionnaire, 2001

Module 3: Quality of Life and Care Giving

8. During the past 30 days, for about how many days have you felt you did not get enough rest or sleep? (227-228)

__ __	Number of days
8 8	None
7 7	Don't know/Not sure
9 9	Refused

Module 7: Asthma History

8. During the past 30 days, how many days did symptoms of asthma make it difficult for you to stay asleep? (276)

Would you say:	**Please Read**
8	None
1	One or two
2	Three to five
3	Six to ten
	or
4	More than ten
Do not read these responses 7	Don't know/Not sure
9	Refused

Behavioral Risk Factor Questionnaire, 2002

10. Have you experienced any of the following feelings or problems, because of the attacks...? **(CHECK ALL THAT APPLY)** (734-749)

Please Read

11=Anger
12=Nervousness
13=Worry
14=Sleep problems (nightmares, sleeplessness, etc.)
15=Hopelessness
16=Loss of control over external events
17=Worthlessness
18=Other

89=No other choices
88=None (Go to Q13)
77=Don't Know/Not Sure
99=Refused

C. CDC Pregnancy Risk Assessment Monitoring System 1999 Surveillance Report

Relevant Questions:

45. How do you put your new baby down to sleep ***most*** of the time?
Check one answer.

- ❒ On his or her side
- ❒ On his or her back
- ❒ On his or her stomach

46. How many times has your baby been to a doctor or nurse for ***routine*** well-baby care?
Don't count the times you took your baby for care when he or she was sick. It may help to use the calendar.

___ Times

- ❒ My baby hasn't been for routine well-baby care —> **Go to Question 48**

47. When your baby goes for ***routine*** well-baby care, where do you take him or her?
Check all the places that you use.

- ❒ Hospital clinic
- ❒ Health department clinic
- ❒ Private doctor's office
- ❒
- ❒
- ❒ Other —> Please tell us:

51. What is today's date?

____/____/____
month day year

52. What is ***your*** date of birth?

____/____/____
month day year

D. Fatality Analysis Reporting System

Relevant Question:

In this data resource on highway traffic fatalities, one choice for a contributing cause to a highway fatality under "Driver-Related Factors" is "Drowsy, sleepy, asleep, fatigued (code 1)."

E. Framingham Heart Study

Relevant Questions:

Relevant information was included in the study's data collection forms. Related sections are included below.

Cohort Data Collection Forms:

The cohort form (one that collects data on original participants) records information on when a cerebrovascular event took place and includes “during sleep” as a response option for the onset.

Details for "Serious" Cerebrovascular Event in Interim		
|__| if yes or maybe fill all to ☞	Examiner's opinion that "serious" or "significant" cerebrovascular event took place in interim (0=No, 1=Yes, 2=Maybe, 9=Unknown)	
	|__|__|*|__|__|	Date (mo/yr,99/99=Unkn Observed by_____
	|__|	Onset time (1=Active, 2=During sleep, 3=While arising, 9=Unkn)
	|__|__|*|__|__|	Exact/approximate time (use 24-hour military time, 99.99=unkn)
	|__|__|*|__|__|*|__|__|	Duration (use format days/hours/mins, 99/99/99=Unknown)
	|__|	Hospitalized or saw M.D. 0=No,1=Hosp.2=Saw M.D,9=Unk
	| | |	Number of days stayed at

In addition, the data collection forms record whether the individual is taking sleeping pills.

Offspring Data Collection Forms:

The Offspring Data Collection Form, as its name implies, collects data on children of the original cohort. In addition to the two questions collected by the Cohort Data Collection Form, the cohort form asks participants to indicate frequency of restless sleep.

CES-D Scale (page 17, #11):

The questions below ask about your feelings during the past week. For each of the following statements, please say if you felt that way much of the time during the past week.

Questions to be answered Circle best answer for each question	Rarely or none of the time (less than 1 day)	Some or a little of the time (1-2 days)	Occasionally or moderate amount of time (3-4 days)	Most or all of the time (5-7 days)	Unknown
11. My sleep was restless.	0	1	2	3	9

F. Global School-Based Survey 2004 Core Questionnaire

Relevant Question:

Mental Health Section:

38. During the past 12 months, how often have you been so worried about something that you could not sleep at night?

A. Never
B. Rarely
C. Sometimes
D. Most of the time
E. Always

G. National Asthma Survey, 2003

Relevant Question:

Section 4. History of Asthma (Symptoms & Episodes):

ASLEEP30 (4.3)

During the past 30 days, on how many days did symptoms of asthma make it difficult for {**you/[the [AGE] year old/NAME]**} to stay asleep?

__ __ DAYS/NIGHTS
[RANGE CHECK: (00-30, 96, 97)]

(00) NONE
(96) DON'T KNOW
(97) REFUSED

H. National Comorbidity Survey, 1990–1992

Relevant Questions:

A6. How many hours do you usually sleep in a 24-hour period?

_____# HOURS

B103. The next few questions are about some reactions you might have had when you were worried or anxious--reactions that could not be entirely explained by a physical illness or injury.....0.....0.....

*B103p. ...trouble falling asleep or staying asleep? *(#16)* * * *

```
*D9.  Have you ever had 2 weeks or more when nearly      *     *64447*     *
*     every night you had trouble falling asleep?        *     *5   5*     *
*                                                        *     *94448*GO TO*
*                                                        * (#6) *     *  D11*

*D10. Have you ever had 2 weeks or more when nearly      *     *     *     *
*     every night it took you at least 2 hours to        *     *     *     *
*     fall asleep?                                       * (#7) *     *     *

*D11. Have you ever had 2 weeks or more when nearly      *     *64447*     *
*     every night you had trouble staying asleep?        *     *5   5*GO TO*
*                                                        * (#8) *94448* D13 *

*D15. Have you ever had 2 weeks or longer when           *     *64447*     *
*     nearly every day you were sleeping too much?       *     *5   5*     *
*                                                        *(#12) *94448*     *

E11.  Has there ever been a period when you hardly slept       *     *64447*     *
      at all but still did not feel tired or sleepy?           *     *5   5*     *
                                                               *(#8)  *94448*     *

*U31.  Did you have more trouble sleeping than     *64447*     *          *
*      is usual for you?                           *5   5*     *          *
*                                                  *94448*     *          *

X3.   Think of the time when his depression was at its worst.  During that time, did
      your father...

*X3d.  Did his sleep habits change?                      *     *     *     *

X8.   Think of the time when his nervousness was at its worst.  During that time,
      did your father ...

*X8a. ... have difficulty falling asleep?                *     *     *     *

X13.  Did he ever abuse prescription drugs such as valium, sleeping pills, or
      diet pills?
      64444447        +)))))),        +)))))))))))))),
      51. YES5        *5. NO*         *8. DON'T KNOW*
      94444448        .)))))-         .))))))))))))))-

X29.  Think of the time when her depression was at its worst.  During that time, did
      your mother...

*X29d. Did her sleep habits change?                      *     *     *     *

X34.  Now think of the time when her nervousness was at its worst.  During that
      time,  did your mother ...

*X34a. ... have difficulty falling asleep?               *     *     *     *
```

```
X39.  Did she ever abuse prescription drugs such as valium, sleeping pills, or
      diet pills?
      64444447        +)))))),        +)))))))))))))),
      51. YES5        *5. NO*         *8. DON'T KNOW*
      94444448        .)))))-         .))))))))))))))-
```

REACTIONS WHEN YOU WERE WORRIED OR ANXIOUS

16. Trouble falling or staying asleep

YOU HAD A PERIOD OF TWO WEEKS OR MORE WHEN YOU …

7. Took at least 2 hours to fall asleep

YOU HAD A PERIOD WHEN YOU(R) …

8. Hardly slept but still did not feel tired or sleepy

I. National Health Interview Survey, 2002

Relevant Questions:

FIJ.200 **FR: VERIFY OR ASK. SHOW FLASHCARD F5. RECORD UP TO 2 RESPONSES: ENTER (N) FOR NO MORE.**

What {were/was} {you/subject name} doing when the injury/poisoning happened?

>WHAT_1< (01) Driving or riding in a motor vehicle
>WHAT_2< (02) Working at a paid job
(03) Working around the house or yard
(04) Attending school
(05) Unpaid work (including housework, shopping, volunteer work)
(06) Sports (organized team or individual sport such as running, biking, skating)
(07) Leisure activity (excluding sports)
(08) Sleeping, resting, eating, drinking
(09) Cooking
(10) Being cared for (hands on care from other person)
(11) Other
(97) Refused
(99) Don't know

Module: Adult Core Questionnaire

Section: Conditions

ACN.125.060 DURING THE PAST 12 MONTHS have you …

>CSYR<

(1) Yes
(2) No
(7) Refused
(9) Don't know

>INSOMYR< ... regularly had insomnia or trouble sleeping?
>FATIGYR< ... regularly had excessive sleepiness during the day?
>PAINYR< ... had recurring pain?

Module: Child Core Questionnaire

Section: Mental Health

CHS.321 I am going to read a list of items that describe children. For each item, please tell me if it has been NOT TRUE, SOMETIMES TRUE, or OFTEN TRUE, of {S.C. name} DURING THE PAST TWO MONTHS.

FR: SHOW FLASHCARD C3

(0) Not True
(1) Sometimes True
(2) Often True
(7) Refused
(9) Don't know

HE:

>CMHAGM12< ... has been uncooperative?
>CMHAGM13< ... has trouble getting to sleep?
>CMHAGM14<... has speech problems?
>CMHAGM15<... has been unhappy, sad, or depressed?

2002 Variable Supplement: Alternative Medicine

Respondents were asked to list any health problems for which they were using alternative therapy. For instance the following question inquired about acupuncture treatment. "Excessive sleepiness during the day (21)" and "insomnia/trouble sleeping (50)" appear as possible coded responses.

ALT.005 For what health problems or conditions did you use acupuncture?

FR: MARK ALL THAT APPLY. ENTER (N) FOR NO MORE.

(1) Yes (7) Refused
(2) No (9) Don't know

>ACUCON01< (01) Allergic reaction to food
>ACUCON02< (02) Allergic reaction to medication
>ACUCON03< (03) Angina
>ACUCON04< (04) Anxiety/depression
>ACUCON05< (05) Arthritis, gout, lupus, or fibromyalgia
>ACUCON06< (06) Asthma
>ACUCON07< (07) Benign tumors, cysts
>ACUCON08< (08) Birth defect
>ACUCON09< (09) Bowel problems or constipation
>ACUCON10< (10) Cancer
>ACUCON11< (11) Cataracts
>ACUCON12< (12) Cholesterol
>ACUCON13< (13) Chronic bronchitis
>ACUCON14< (14) Recurring pain
>ACUCON15< (15) Circulation problems (other than in the legs)
>ACUCON16< (16) Congestive heart failure
>ACUCON17< (17) Coronary heart disease
>ACUCON18< (18) Diabetes
>ACUCON19< (19) Diabetic retinopathy
>ACUCON20< (20) Emphysema
>ACUCON21< (21) Excessive sleepiness during the day
>ACUCON22< (22) Jaw pain
>ACUCON23< (23) Fracture, bone/joint injury
>ACUCON24< (24) Glaucoma
>ACUCON25< (25) Gynecologic problems
>ACUCON26< (26) Hay fever
>ACUCON27< (27) Hearing problem
>ACUCON28< (28) Heart attack
>ACUCON29< (29) Heart condition or disease
>ACUCON30< (30) Hernia
>ACUCON31< (31) Hypertension
>ACUCON32< (32) Irregular heartbeat
>ACUCON33< (33) Knee problems (not arthritis, not joint injury)
>ACUCON34< (34) Lung/breathing problem (not already listed)
>ACUCON35< (35) Macular degeneration
>ACUCON36< (36) Menopause
>ACUCON37< (37) Menstrual problems
>ACUCON38< (38) Mental retardation

>ACUCON39< (39) Joint pain or stiffness
>ACUCON40< (40) Missing limbs (fingers, toes, or digits), amputee
>ACUCON41< (41) Multiple sclerosis
>ACUCON42< (42) Neuropathy
>ACUCON43< (43) Osteoporosis, tendinitis
>ACUCON44< (44) Other developmental problem
>ACUCON45< (45) Other injury
>ACUCON46< (46) Other nerve damage, including carpal tunnel syndrome
>ACUCON47< (47) Parkinson's
>ACUCON48< (48) Polio (myelitis), paralysis, para/quadriplegia
>ACUCON49< (49) Poor circulation in your legs
>ACUCON50< (50) Insomnia or trouble sleeping
>ACUCON51< (51) Liver problem
>ACUCON52< (52) Dental pain
>ACUCON53< (53) Prostate trouble or impotence
>ACUCON54< (54) Seizures
>ACUCON55< (55) Senility
>ACUCON56< (56) Sinusitis
>ACUCON57< (57) Skin problems
>ACUCON58< (58) Sprain or strain
>ACUCON59< (59) Stroke
>ACUCON60< (60) Text of first other specify
>ACUCON61< (61) Text of second other specify
>ACUCON62< (62) Thyroid problem
>ACUCON63< (63) Ulcer
>ACUCON64< (64) Urinary problem
>ACUCON65< (65) Varicose veins, hemorrhoids
>ACUCON66< (66) Vision problems (not already listed)
>ACUCON67< (67) Weak or failing kidneys
>ACUCON68< (68) Weight problems
>ACUCON69< (69) Back pain or problem
>ACUCON70< (70) Head or chest cold
>ACUCON71< (71) Neck pain or problem
>ACUCON72< (72) Severe headache or migraine
>ACUCON73< (73) Stomach or intestinal illness
>ACUCON74< (74) Other, specify

J. National Health and Nutrition Examination Survey

Relevant Questions:

Codebook for Data Release (2001-2002)
NHANES Composite International Diagnostic Interview-
Major Depression Module (CIQDEP_B)
Person level data -- use CIDI Weights for analysis
February 2005

CIQD018
B(20 Yrs. to 39 Yrs.)
When irritable, did you lack energy?
English Text: For the next questions, please think of the two weeks during the past 12 months when you were irritable and had the largest number of these other problems. During that two-week period, did you lack energy or feel tired all the time nearly every day, even when you had not been working very hard? English Instructions: (IF R SAYS THERE WAS NO SINGLE TWO-WEEK PERIOD THAT STANDS OUT, SAY: Then think of the most recent two weeks of this sort.) (Collection name = E2_1C_1)

CIQD025
B(20 Yrs. to 39 Yrs.)
During 2 weeks, trouble sleep?
English Text: Did you have a lot more trouble than usual sleeping for these two weeks -- either trouble falling asleep, waking in the middle of the night, or waking up too early?
English Instructions: (Collection name = E8)

CIQD026
B(20 Yrs. to 39 Yrs.)
Frequency trouble sleeping
English Text: Did this happen every night, nearly every night, or less often during those two weeks? English Instructions: (Collection name = E8_1)

Codes:
Skip To Values:
1= Every night
2= Nearly every night
3= Less often
7= Refuse
9= Don't know

CIQD027
B(20 Yrs. to 39 Yrs.)
Did you wake up 2 hours early?
English Text: Did you wake up at least two hours before you wanted to every day during these two weeks? English Instructions: (Collection name = E8A)

CIQD028
B(20 Yrs. to 39 Yrs.)
Did you sleep too much?
English Text: Did you sleep too much almost every day?

K. National Household Survey on Drug Abuse

Relevant Questions:

DRALC11 [IF DRALC09 = 1 OR DRALC10 = 1] Please look at the symptoms listed below. During the past 12 months, did you have **2 or** more of these symptoms after you cut back or stopped drinking **alcohol**?

- Sweating or feeling that your heart was beating fast
- Having your hands tremble
- Having trouble sleeping
- Vomiting or feeling nauseous
- Seeing, hearing, or feeling things that weren't really there
- Feeling like you couldn't sit still
- Feeling anxious
- Having seizures or fits

1 Yes
2 No
DK/REF

DRALC12 [IF DRALC11 = 1] Please look at the symptoms listed below. During the past 12 months, did you have **2 or more of these symptoms at the same time** that lasted for longer than a day after you cut back or stopped drinking **alcohol**?

- Sweating or feeling that your heart was beating fast
- Having your hands tremble
- Having trouble sleeping
- Vomiting or feeling nauseous
- Seeing, hearing, or feeling things that weren't really there
- Feeling like you couldn't sit still
- Feeling anxious
- Having seizures or fits

1 Yes
2 No
DK/REF

DRCC11 [IF DRCC10a = 1] Please look at the symptoms listed below. During the past 12 months, did you have **2 or more** of these symptoms after you cut back or stopped using **[COKEFILL]**?

- Feeling tired or exhausted
- Having bad dreams
- Having trouble sleeping or sleeping more than you normally do
- Feeling hungry more often
- Feeling either very slowed down or like you couldn't sit still

1 Yes
2 No
DK/REF

DRCC12 [IF DRCC11 = 1] Please look at the symptoms listed below. During the past 12 months, did you have **2 or more of these symptoms at the same time** that lasted for longer than a day after you cut back or stopped using **[COKEFILL]**?

- Feeling tired or exhausted
- Having bad dreams
- Having trouble sleeping or sleeping more than you normally do
- Feeling hungry more often
- Feeling either very slowed down or like you couldn't sit still

1 Yes
2 No
DK/REF

DRHE11 [IF DRHE09 = 1 OR DRHE10 = 1] Please look at the symptoms listed below. During the past 12 months, did you have **3 or more** of these symptoms after you cut back or stopped using **heroin**?

- Feeling kind of blue or down
- Vomiting or feeling nauseous
- Having cramps or muscle aches
- Having teary eyes or a runny nose
- Feeling sweaty, having enlarged eye pupils, or having body hair standing up on your skin
- Having diarrhea
- Yawning
- Having a fever
- Having trouble sleeping

1 Yes
2 No
DK/REF

DRHE12 [IF DRHE11 = 1] Please look at the symptoms listed below. During the past 12 months, did you have **3 or more of these symptoms at the same time** that lasted for longer than a day after you cut back or stopped using **heroin**?

- Feeling kind of blue or down
- Vomiting or feeling nauseous
- Having cramps or muscle aches
- Having teary eyes or a runny nose
- Feeling sweaty, having enlarged eye pupils, or having body hair standing up on your skin
- Having diarrhea
- Yawning
- Having a fever
- Having trouble sleeping

1 Yes
2 No
DK/REF

DRPR11 [IF DRPR09 = 1 OR DRPR10 = 1] Please look at the symptoms listed below. During the past 12 months, did you have **3 or more** of these symptoms after you cut back or stopped using **prescription pain relievers**?

- Feeling kind of blue or down
- Vomiting or feeling nauseous
- Having cramps or muscle aches
- Having teary eyes or a runny nose
- Feeling sweaty, having enlarged eye pupils, or having body hair standing up on your skin
- Having diarrhea
- Yawning
- Having a fever
- Having trouble sleeping

1 Yes
2 No
DK/REF

DRPR12 [IF DRPR11 = 1] Please look at the symptoms listed below. During the past 12 months, did you have **3 or more of these symptoms at the same time** that lasted for longer than a day after you cut back or stopped using **prescription pain relievers**?

- Feeling kind of blue or down
- Vomiting or feeling nauseous
- Having cramps or muscle aches
- Having teary eyes or a runny nose
- Feeling sweaty, having enlarged eye pupils, or having body hair standing up on your skin
- Having diarrhea
- Yawning
- Having a fever
- Having trouble sleeping

1 Yes
2 No
DK/REF

DRST11 [IF DRST10a = 1] Please look at the symptoms listed below. Please look at the symptoms listed below. During the past 12 months, did you have **2 or more** of these symptoms after you cut back or stopped using **prescription stimulants**?

- Feeling tired or exhausted
- Having bad dreams
- Having trouble sleeping or sleeping more than you normally do
- Feeling hungry more often
- Feeling either very slowed down or like you couldn't sit still

1 Yes
2 No
DK/REF

DRST12 [IF DRST11 = 1] Please look at the symptoms listed below. During the past 12 months, did you have **2 or more of these symptoms at the same time** that lasted for longer than a day after you cut back or stopped using **prescription stimulants**?

- Feeling tired or exhausted
- Having bad dreams
- Having trouble sleeping or sleeping more than you normally do
- Feeling hungry more often
- Feeling either very slowed down or like you couldn't sit still

1 Yes
2 No
DK/REF

DRSV11 [IF DRSV09 = 1 OR DRSV10 = 1] Please look at the symptoms listed below. During the past 12 months, did you have **1 or more** of these symptoms after you cut back or stopped using **prescription sedatives**?

- Sweating or feeling that your heart was beating fast
- Having your hands tremble
- Having trouble sleeping or sleeping more than you normally do
- Vomiting or feeling nauseous
- Seeing, hearing, or feeling things that weren't really there
- Feeling like you couldn't sit still
- Feeling anxious
- Having seizures or fits

1 Yes
2 No
DK/REF

DRSV12 [IF DRSV11 = 1] Please look at the symptoms listed below. During the past 12 months, did you have **1 or more of these symptoms at the same time** that lasted for longer than a day after you cut back or stopped using **prescription sedatives**?

- Sweating or feeling that your heart was beating fast
- Having your hands tremble
- Having trouble sleeping or sleeping more than you normally do
- Vomiting or feeling nauseous
- Seeing, hearing, or feeling things that weren't really there
- Feeling like you couldn't sit still
- Feeling anxious
- Having seizures or fits

1 Yes
2 No
DK/REF

DEFEELPR [IF DEDAYSAD = 1 OR 2 OR 3] During those [DEWEEK1 FILL] weeks when you felt sad or depressed, did you also have any changes in sleep, energy, appetite, or the ability to concentrate?

1 Yes
2 No
DK/REF

DELOSTPR [IF DEDAYLST=1 OR 2 OR 3] During those [DEWEEK2 FILL] weeks when you lost interest in things, did you also have any changes in sleep, energy, appetite, or your ability to concentrate?

1 Yes
2 No
DK/REF

MASLEEP [IF MAFEEL=1] During the time when you were extremely excited or hyper, did you find that you could hardly sleep at all but still you didn't feel tired?

1 Yes
2 No
DK/REF

GAPROB [IF GAWORSTR=1-4 AND GAWORLOT=1] During those [GAWEEK1 FILL] weeks when you were so worried, did you have other problems, like difficulties in sleep or concentration, or feeling dizzy, easily tired, on edge, or irritable?

[IF GAWORSTR=1-4 AND GANERVLOT=1] During those [GAWEEK1 FILL] weeks when you were so nervous or anxious, did you have other problems, like difficulties in sleep or concentration, or feeling dizzy, easily tired, on edge, or irritable?

1 Yes
2 No
DK/REF

PTREACT [IF PTEXPER=1] After experiences like this, people sometimes have reactions like memories that are upsetting, feeling emotionally distant from other people, trouble sleeping or concentrating, and feeling jumpy or easily startled. \

During the past 12 months, did you have any of these reactions to any extremely stressful experience, even if the experience was long ago?

1 YES
2 NO
DK/REF

L. National Sleep Foundation, Sleep in America Poll

Relevant Questions:

The complete questionnaire is included.

National Sleep Foundation
2005 Sleep in America Poll
Screening Questionnaire

Respondent Name: _____

Telephone Number: _____

Hello, my name is ____ with WB&A, a national research firm. I am calling on behalf of the National Sleep Foundation to conduct a survey about sleep among Americans. This is not a sales call; it is a national research survey. It will take a few minutes of your time and your responses will be kept strictly confidential.

S1. Are you 18 years of age or older?

01 Yes ➔ **CONTINUE**

02 No ➔ **ASK TO SPEAK TO SOMEONE 18 YEARS OR OLDER AND RETURN TO INTRODUCTION.**

S2. **RECORD, DO NOT ASK:** Gender

01 Male ➔ **QUOTA (n=750)**

02 Female ➔ **QUOTA (n=750)**

S3. What is your marital status? Are you…**(READ LIST)**

01 Married,
02 Single,
03 Living with someone,
04 Divorced,
05 Separated, or
06 Widowed?
98 **DO NOT READ:** Refused

S4. **RECORD FROM SAMPLE:** Region

01 Northeast (1) ➔ **QUOTA (n=285)**
02 Midwest (2) ➔ **QUOTA (n=360)**
03 South (3) ➔ **QUOTA (n=540)**
04 West (4) ➔ **QUOTA (n=315)**

****GO TO MAIN QUESTIONNAIRE****

2005 SLEEP IN AMERICA POLL
MAIN QUESTIONNAIRE

SECTION 1: SLEEP HABITS -- ASK EVERYONE

As I mentioned earlier, this survey is about sleep habits among Americans. Keep in mind, there are no right or wrong answers. First, I would like to ask you some general questions regarding sleep. Please think about your sleep schedule in the past two weeks.

1. At what time do you usually get up on days you work or on weekdays? **(DO NOT READ LIST.)**

01	12:00 AM (Midnight)	15	8:00 AM – 8:14 AM
02	12:01 AM – 4:59 AM	16	8:15 AM – 8:29 AM
03	5:00 AM – 5:14 AM	17	8:30 AM – 8:44 AM
04	5:15 AM – 5:29 AM	18	8:45 AM – 8:59 AM
05	5:30 AM – 5:44 AM	19	9:00 AM – 9:14 AM
06	5:45 AM – 5:59 AM	20	9:15 AM – 9:29 AM
07	6:00 AM – 6:14 AM	21	9:30 AM – 9:44 AM
08	6:15 AM – 6:29 AM	22	9:45 AM – 9:59 AM
09	6:30 AM – 6:44 AM	23	10:00 AM – 10:59 AM
10	6:45 AM – 6:59 AM	24	11:00 AM – 11:59 AM
11	7:00 AM – 7:14 AM	25	12:00 PM (Noon) – 5:59 PM
12	7:15 AM – 7:29 AM	26	6:00 PM – 11:59 PM
13	7:30 AM – 7:44 AM	98	Refused
14	7:45 AM – 7:59 AM	99	Don't know

2. At what time do you usually go to bed on nights before workdays or weekdays? **(DO NOT READ LIST.)**

01	12:00 AM (Midnight)	13	9:45 PM – 9:59 PM
02	12:01 AM – 12:59 AM	14	10:00 PM – 10:14 PM
03	1:00 AM – 1:59 AM	15	10:15 PM – 10:29 PM
04	2:00 AM – 5:00 AM	16	10:30 PM – 10:44 PM
05	5:01 AM – 8:59 AM	17	10:45 PM – 10:59 PM
06	9:00 AM – 11:59 AM	18	11:00 PM – 11:14 PM
07	12:00 PM (Noon) – 6:59 PM	19	11:15 PM – 11:29 PM
08	7:00 PM – 7:59 PM	20	11:30 PM – 11:44 PM
09	8:00 PM – 8:59 PM	21	11:45 PM – 11:59 PM
10	9:00 PM – 9:14 PM	98	Refused
11	9:15 PM – 9:29 PM	99	Don't know
12	9:30 PM – 9:44 PM		

3. On workdays or weekdays, how many hours, not including naps, do you usually sleep during one night?
(RECORD NUMBER OF HOURS AND MINUTES BELOW. DO NOT ACCEPT RANGES. RECORD 98 FOR REFUSED AND 99 FOR DON'T KNOW.)

Hours: _____

Minutes: _____

4. Thinking about your usual non-workday or weekend, please answer the following questions.

At what time do you usually get up on days you do not work or weekends? **(DO NOT READ LIST.)**

01	12:00 AM (Midnight)	14	7:45 AM – 7:59 AM
02	12:01 AM – 4:59 AM	15	8:00 AM – 8:14 AM
03	5:00 AM – 5:14 AM	16	8:15 AM – 8:29 AM
04	5:15 AM – 5:29 AM	17	8:30 AM – 8:44 AM
05	5:30 AM – 5:44 AM	18	8:45 AM – 8:59 AM
06	5:45 AM – 5:59 AM	19	9:00 AM – 9:14 AM
07	6:00 AM – 6:14 AM	20	9:15 AM – 9:29 AM
08	6:15 AM – 6:29 AM	21	9:30 AM – 9:44 AM
09	6:30 AM – 6:44 AM	22	9:45 AM – 9:59 AM
10	6:45 AM – 6:59 AM	23	10:00 AM – 10:59 AM
11	7:00 AM – 7:14 AM	24	11:00 AM – 11:59 AM
12	7:15 AM – 7:29 AM	25	12:00 PM (Noon) – 5:59 PM
13	7:30 AM – 7:44 AM	26	6:00 PM – 11:59 PM
		98	Refused
		99	Don't know

5. At what time do you usually go to bed on nights you do not work the next day or weekends? **(DO NOT READ LIST.)**

01	12:00 AM (Midnight)	13	9:45 PM – 9:59 PM
02	12:01 AM – 12:59 AM	14	10:00 PM – 10:14 PM
03	1:00 AM – 1:59 AM	15	10:15 PM – 10:29 PM
04	2:00 AM – 5:00 AM	16	10:30 PM – 10:44 PM
05	5:01 AM – 8:59 AM	17	10:45 PM – 10:59 PM
06	9:00 AM – 11:59 AM	18	11:00 PM – 11:14 PM
07	12:00 PM (Noon) – 6:59 PM	19	11:15 PM – 11:29 PM
08	7:00 PM – 7:59 PM	20	11:30 PM – 11:44 PM
09	8:00 PM – 8:59 PM	21	11:45 PM – 11:59 PM
10	9:00 PM – 9:14 PM	98	Refused
11	9:15 PM – 9:29 PM	99	Don't know
12	9:30 PM – 9:44 PM		

6. On days you do not work or on weekends, how many hours, not including naps, do you usually sleep during one night? **(RECORD NUMBER OF HOURS AND MINUTES BELOW. DO NOT ACCEPT RANGES. RECORD 98 FOR REFUSED AND 99 FOR DON'T KNOW.)**

Hours: _____

Minutes: _____

6a. How often do you stay up later than you planned or wanted to on weeknights? Would you say…**(READ LIST.)**

05 Every night or almost every night,
04 A few nights a week,
03 A few nights a month,
02 Rarely, or
01 Never?
98 **DO NOT READ:** Refused
99 **DO NOT READ:** Don't know

6b. Thinking about your sleep and sleep habits within the past month, how often have you done the following in the hour before you went to bed? Would you say that in the past month you…**(READ LIST. RANDOMIZE.)** within an hour of going to bed every night or almost every night, a few nights a week, a few nights a month, rarely or never?

	Every night or almost every night	A few nights a week	A few nights a month	Rarely	Never	Refused	Don't know
a. Did work relating to your job	05	04	03	02	01	98	99
b. Watched TV	05	04	03	02	01	98	99
c. Listened to the radio or music	05	04	03	02	01	98	99
d. Were on the Internet	05	04	03	02	01	98	99
e. Read	05	04	03	02	01	98	99
f. Had sex	05	04	03	02	01	98	99
g. Exercised	05	04	03	02	01	98	99
h. Spent time with family/friends	05	04	03	02	01	98	99
i. Drank an alcoholic beverage	05	04	03	02	01	98	99
j. Took a hot bath/shower	05	04	03	02	01	98	99

6c. Do you have any of the following in your bedroom? **(READ LIST. RANDOMIZE.)**

	Yes	No	Refused	Don't know
a. Television	01	02	98	99
b. Computer	01	02	98	99
c. Telephone	01	02	98	99
d. Radio/Stereo/DVD	01	02	98	99

7. How long, on most nights, does it take you to fall asleep? Would you say… **(READ LIST.)**

01 Less than 5 minutes,
02 5 up to 10 minutes,
03 10 up to 15 minutes,
04 15 up to 30 minutes,
05 30 up to 45 minutes,
06 45 minutes up to 1 hour, or
07 1 hour or more?
08 **DO NOT READ:** Depends/Varies
98 **DO NOT READ:** Refused
99 **DO NOT READ:** Don't know/Not sure

8. Most nights, do you sleep…**(READ LIST. MULTIPLE RESPONSES ACCEPTED EXCEPT WITH 01.)**

01 Alone,
02 With your significant other,
03 With your children,
04 With a pet, or
95 Something else? (SPECIFY) _____
98 **DO NOT READ:** Refused
99 **DO NOT READ:** Don't know

9. Most nights, do you prefer to sleep…**(READ LIST. MULTIPLE RESPONSES ACCEPTED EXCEPT WITH 01.)**

01 Alone,
02 With your significant other,
03 With your children,
04 With a pet, or
95 Something else? (SPECIFY) _____
98 **DO NOT READ:** Refused
99 **DO NOT READ:** Don't know

10. If you thought you had a sleep problem, what would you be likely to do? Would you…**(READ LIST. MULTIPLE RESPONSES ACCEPTED.)**

01 Assume it will go away in time,
02 Use an over-the-counter sleep aid,
03 Talk to your doctor,
04 Self-treat it (using something other than OTC sleep aids),
05 Get recommendations from family/friends, or
95 Something else? **(SPECIFY)** _____
96 **DO NOT READ:** Nothing
98 **DO NOT READ:** Refused
99 **DO NOT READ:** Don't know

11. Do you think you have a sleep problem? **(DO NOT READ LIST.)**

01 Yes
02 No
03 Maybe
98 **DO NOT READ:** Refused
99 **DO NOT READ:** Don't know/Not sure

12. On average, how many times during the week do you take a nap? Would you say…**(READ LIST.)**

01 None, ➔ **SKIP TO Q14**
02 1 time,
03 2 or 3 times, ➔ **CONTINUE**
04 4 or 5 times, or
05 More than 5 times?
98 **DO NOT READ:** Refused ➔ SKIP TO Q14
99 DO NOT READ: Don't know

IF"03-05" IN Q12, ASK Q13. OTHERWISE SKIP TO Q14.

13. On average, how long would you say you usually nap? Would you say…**(READ LIST.)**

01 Less than 15 minutes,
02 15 to less than 30 minutes,
03 30 to less than 45 minutes,
04 45 minutes to less than 1 hour, or
05 1 hour or more?
98 **DO NOT READ:** Refused
99 **DO NOT READ:** Don't know

SECTION 2: SLEEP PROBLEMS/DISORDERS -- ASK EVERYONE

14. How often have you had each of the following in the past year? Would you say **(READ LIST. RANDOMIZE.)** every night or almost every night, a few nights a week, a few nights a month, rarely, or never?

	Every night or almost every night	A few nights a week	A few nights a month	Rarely	Never	Refused	Don't know
a. You had difficulty falling asleep	05	04	03	02	01	98	99
b. You were awake a lot during the night	05	04	03	02	01	98	99
c. You woke up too early and could not get back to sleep	05	04	03	02	01	98	99
d. You woke up feeling unrefreshed	05	04	03	02	01	98	99

15. I would like to ask you about your experiences with specific sleep-related problems or disorders. In the past year, according to your own experiences or what others tell you, how often did you…**(READ LIST. RANDOMIZE.)** Would you say every night or almost every night, a few nights a week, a few nights a month, rarely, or never?

	Every night or almost every night	A few nights a week	A few nights a month	Rarely	Never	Refused	Don't know
a. Have unpleasant feelings in your legs like creepy, crawly or tingly feelings at night with an urge to move when you lie down to sleep.	05	04	03	02	01	98	99
b. Move your body frequently or have twitches often during the night.	05	04	03	02	01	98	99

IF Q15a (02-05), ASK Q16. OTHERWISE SKIP TO Q17.

16. Would you say these feelings in your legs are worse, about the same as, or better at night or in the evening compared to other times of the day? **(DO NOT READ LIST.)**

01 Worse at night
02 About the same as
03 Better at night
98 Refused
99 Don't know

ASK EVERYONE

17. According to your own experiences or what others tell you, do you snore? **(DO NOT READ LIST.)**

01 Yes **➔ CONTINUE**
02 No
98 Refused **➔ SKIP TO Q21**
99 Don't know

IF YES (01) IN Q17, ASK Q18. OTHERWISE, SKIP TO Q21.

18. Would you say your snoring is…**(READ LIST.)**

04 Slightly louder than breathing,
03 As loud as talking,
02 Louder than talking, or
01 Very loud and can be heard in adjacent rooms?
98 **DO NOT READ:** Refused
99 **DO NOT READ:** Don't know

19. How often would you say that you snore? Would you say you snore…**(READ LIST.)**

05 Every night or almost every night,
04 3 to 4 nights a week,
03 1 to 2 nights a week, or
02 1 to 2 nights a month?
01 **DO NOT READ:** Never/Less often
98 **DO NOT READ:** Refused
99 **DO NOT READ:** Don't know

20. Has your snoring ever bothered others? **(DO NOT READ LIST.)**

01 Yes
02 No
98 Refused
99 Don't know

ASK EVERYONE

21. According to your own experiences or what others have told you, how often have you quit breathing during your sleep? Would you say…**(READ LIST.)**

05 Every night or almost every night,
04 3 to 4 nights a week,
03 1 to 2 nights a week,
02 1 to 2 nights a month, or
01 Never?
98 **DO NOT READ:** Refused
99 **DO NOT READ:** Don't know

22. On a scale of 1 to 5 where a 1 means no impact and a 5 means severe impact, how severe is the impact of your sleep problems on your daily activities? **(DO NOT READ LIST.)**

05 5 - Severe impact
04 4
03 3
02 2
01 1 - No impact
98 **DO NOT READ:** Refused
99 **DO NOT READ:** Don't know

IF MARRIED (01) OR LIVING WITH SOMEONE (03) IN QS3, ASK Q23. OTHERWISE SKIP TO Q28.

23. As a result of a sleep problem, do you or does your partner do any of the following to ensure that you both get a good night sleep…**(READ LIST. RANDOMIZE.)**

	Yes	No	Refused	Don't know
a. Sleep in a separate bed, bedroom or on the couch	01	02	98	99
b. Alter your sleep schedules	01	02	98	99
c. Sleep with earplugs or an eye mask	01	02	98	99

24. Did your partner have any of the following within the past year? Did…**(READ LIST. RANDOMIZE.)**

	Yes	No	Not sure	Refused	Don't know
a. He or she have difficulty falling asleep	01	02	03	98	99
b. He or she wake a lot during the night	01	02	03	98	99
c. He or she wake up too early and could not get back to sleep	01	02	03	98	99
d. He or she wake up feeling unrefreshed	01	02	03	98	99

25. Now, I would like to ask you about your partner's experiences with specific sleep-related problems or disorders. In the past year, did your partner…**(READ LIST. RANDOMIZE.)**

	Yes	No	Not sure	Refused	Don't know
a. Snore	01	02	03	98	99
b. Have pauses in his or her breathing during sleep	01	02	03	98	99
c. Have unpleasant feelings in his or her legs like creepy, crawly or tingly feelings at night with an urge to move when he or she lied down to sleep	01	02	03	98	99
d. Move his or her body frequently or have twitches often during the night	01	02	03	98	99

26. On a typical night, how much sleep do you lose because of your partner's sleep problems? **(RECORD NUMBER OF MINUTES BELOW. DO NOT ACCEPT RANGES. RECORD 998 FOR REFUSED, 999 FOR DON'T KNOW AND 000 FOR NONE.)**

Minutes: _____

27. How much of a problem do your or your partner's sleep disorders have on your relationship? Would you say it causes…**(READ LIST.)**

01 Significant problems,
02 Moderate problems,
03 Little problems, or
04 No problems?
98 **DO NOT READ:** Refused
99 **DO NOT READ:** Don't know

ASK EVERYONE

28. On how many nights can you say "I had a good night's sleep." Would you say…**(READ LIST)**

05 Every night or almost every night,
04 A few nights a week,
03 A few nights a month,
02 Rarely, or
01 Never?
98 **DO NOT READ:** Refused
99 **DO NOT READ:** Don't know

SECTION 3: HEALTH CARE -- ASK EVERYONE

29. Has a doctor ever asked you about your sleep? **(DO NOT READ LIST.)**

01 Yes
02 No
98 Refused
99 Don't know

30. What, if anything, awakens you during the night? **(DO NOT READ LIST. MULTIPLE RESPONSES ACCEPTED.)**

01 Noise
02 Light
03 Stress
04 Thinking about work, something else
05 Someone else
06 Pain/Discomfort
07 Nightmares
08 World events
09 The need to go to the bathroom
10 Wake up for no apparent reason
95 Something else **(SPECIFY)** _____
96 Nothing awakens me at night
98 Refused
99 Don't know

31. If you awaken during the night, how difficult is it for you to fall back asleep? Would you say it is…**(READ LIST.)**

01 Very difficult,
02 Somewhat difficult,
03 Not very difficult, or
04 Not at all difficult?
98 **DO NOT READ:** Refused
99 **DO NOT READ:** Don't know

SECTION 4: MEDICATIONS -- ASK EVERYONE

32. How frequently do you use the following sleep aids specifically to help you sleep? Would you say you use **(READ LIST. RANDOMIZE.)** every night or almost every night, a few nights a week, a few nights a month, rarely, or never?

	Every night or almost every night	A few night a week	A few nights a month	Rarely	Never	Refused	Don't know
a. Over-the-counter or store-bought sleep aids	05	04	03	02	01	98	99
b. Sleep medication prescribed by a doctor	05	04	03	02	01	98	99
c. Alcohol, beer or wine	05	04	03	02	01	98	99
d. An eye mask or earplugs	05	04	03	02	01	98	99
e. Melatonin	05	04	03	02	01	98	99

SECTION 5: DAYTIME SLEEPINESS -- ASK EVERYONE

33. How often do you feel tired or fatigued after your sleep? Would you say…**(READ LIST.)**

05 Every day or almost every day,
04 3 to 4 days a week,
03 1 to 2 days a week,
02 1 to 2 days a month, or
01 Never?
98 **DO NOT READ:** Refused
99 **DO NOT READ:** Don't know

34. During your wake time, how often do you feel tired, fatigued or not up to par? Would you say…**(READ LIST.)**

05 Every day or almost every day,
04 3 to 4 days a week,
03 1 to 2 days a week,
02 1 to 2 days a month, or
01 Never?
98 **DO NOT READ:** Refused
99 **DO NOT READ:** Don't know

35. What wakes you up in the morning? **(DO NOT READ LIST. MULTIPLE RESPONSES ACCEPTED.)**

01 Alarm clock
02 Bed partner
03 Children
04 Light
05 Pet
06 Radio/Television
07 Wake up on own
95 Other **(SPECIFY)** _____
98 Refused
99 Don't know

36. What is the minimum number of hours you need to sleep to function at your best during the day? **(RECORD NUMBER OF HOURS AND MINUTES BELOW. DO NOT ACCEPT RANGES. RECORD 98 FOR REFUSED AND 99 FOR DON'T KNOW.)**

Hours: _____

Minutes: _____

37. If you were late or tardy to work, was it because…**(READ LIST. MULTIPLE RESPONSES ACCEPTED.)**

01 You went to bed too late,
02 You slept too late,
03 You were too sleepy when you woke up,
04 You have a sleep problem,
05 Traffic or transportation problems,
06 You needed to take care of others, or
97 You are never late or tardy?
08 **DO NOT READ:** Do not work ➔ **SKIP TO QUESTION 40**
96 **DO NOT READ:** None of the above
98 **DO NOT READ:** Refused
99 **DO NOT READ:** Don't know

IF DO NOT WORK (08) IN Q37, SKIP TO Q40.

38. How many days within the past three months have you missed work because you were too sleepy or you had a sleep problem? Would you say…**(READ LIST.)**

01 None,
02 1 to 2 days,
03 3 to 5 days,
04 6 to 10 days, or
05 More than 10 days?
98 **DO NOT READ:** Refused
99 **DO NOT READ:** Don't know

39. Thinking about the past three months, how many days did you make errors at work because you were too sleepy or you had a sleep problem? Would you say…**(READ LIST.)**

01 None,
02 1 to 2 days,
03 3 to 5 days,
04 6 to 10 days, or
05 More than 10 days?
98 **DO NOT READ:** Refused
99 **DO NOT READ:** Don't know

ASK EVERYONE

40. How many days within the past three months have you missed family events, leisure activities, work functions or other activities because you were too sleepy or you had a sleep problem? Would you say…**(READ LIST.)**

01 None,
02 1 to 2 days,
03 3 to 5 days,
04 6 to 10 days, or
05 More than 10 days?
98 **DO NOT READ:** Refused
99 **DO NOT READ:** Don't know

41. Has your intimate or sexual relationship been affected because you were too sleepy? That is, did you have sex less often or lose interest in having sex because you were too sleepy? **(DO NOT READ LIST.)**

01 Yes
02 No
96 No intimate or sexual relationship
98 Refused
99 Don't know

42. If you watch the news or a violent program on TV before you go to bed, what impact, if any, does this have on your sleep? Would you say it…**(READ LIST. MULTIPLE RESPONSES ACCEPTED.)**

01 Makes it difficult for you to fall asleep,
03 Causes you to have disturbed or restless sleep,
95 Has some other impact on your sleep **(SPECIFY)** _____
04 Or does it have no impact on your sleep?
96 **DO NOT READ:** Do not watch TV/these programs before bed
98 **DO NOT READ:** Refused
99 **DO NOT READ:** Don't know

43. How concerned are you about current events, such as the war in Iraq, terrorism, the economy or the upcoming election? Would you say you are…**(READ LIST.)**

01 Very concerned,
02 Somewhat concerned,
03 Not really concerned, or
04 Not at all concerned?
98 **DO NOT READ:** Refused
99 **DO NOT READ:** Don't know

SECTION 6: SLEEP EXPERIENCES -- ASK EVERYONE

44. Now I am going to read you a few statements. Please tell me if you completely agree, mostly agree, mostly disagree or completely disagree with each statement. **(READ LIST. RANDOMIZE.)**

	Completely Agree	Mostly Agree	Mostly Disagree	Completely Disagree	Refused	Don't know
a. You can learn to function well over time with one or two fewer hours of sleep than you need.	04	03	02	01	98	99
b. Doctors should discuss sleep issues with their patients.	04	03	02	01	98	99
c. Sleep problems are associated with being overweight or obese.	04	03	02	01	98	99
d. Insufficient or poor sleep is associated with health problems.	04	03	02	01	98	99

45. Would you consider yourself a morning person or an evening person? That is are you more alert, productive and energetic in the morning or evening? **(DO NOT READ LIST.)**

01 Morning person
02 Evening person
98 Refused
99 Don't know

46. Thinking about caffeinated beverages such as soda, soft drinks, coffee and tea, how many cups or cans of caffeinated beverages do you typically drink each day? **(RECORD NUMBER BELOW. DO NOT ACCEPT RANGES. RECORD 99 FOR "DON'T KNOW", 98 FOR "REFUSED", 00 FOR "NONE" AND 97 FOR "LESS THAN ONE".)**

Caffeinated beverages: _____

47. Now, thinking about alcoholic beverages such as beer, wine, liquor or mixed drinks, how many alcoholic beverages do you typically drink each week? **(RECORD NUMBER BELOW. DO NOT ACCEPT RANGES. RECORD 99 FOR "DON'T KNOW", 98 FOR "REFUSED", 00 FOR "NONE" AND 97 FOR "LESS THAN ONE".)**

Alcoholic beverages: _____

SECTION 7: DROWSY DRIVING -- ASK EVERYONE

48. In the past year, how often have you driven a car or motor vehicle while feeling drowsy? Would you say…**(READ LIST.)**

05 3 or more times a week,
04 1 to 2 times a week,
03 1 to 2 times a month,
02 Less than once a month, or
01 Never?
96 **DO NOT READ:** Don't drive/Don't have a license ➔ **SKIP TO Q53**
98 **DO NOT READ:** Refused
99 **DO NOT READ:** Don't know

IF DON'T DRIVE OR DON'T HAVE A LICENSE (96) IN Q48, SKIP TO Q53.

49. In the past year, have you had an accident or a near accident because you dozed off or were too tired while driving? **(DO NOT READ LIST.)**

01 Yes ➔ **CONTINUE**
02 No
98 Refused ➔ **SKIP TO Q51**
99 Don't know

IF YES (01) IN Q49, ASK Q50. OTHERWISE SKIP TO Q51.

50. In the past year, how often have you had an accident or a near accident because you dozed off or were too tired while driving? Would you say…**(READ LIST.)**

05 3 or more times a week,
04 1 to 2 times a week,
03 1 to 2 times a month,
02 Less than once a month, or
01 Never?
98 **DO NOT READ:** Refused
99 **DO NOT READ:** Don't know

IF DON'T DRIVE OR DON'T HAVE A LICENSE (96) IN Q48, SKIP TO Q53.

51. Have you ever nodded off or fallen asleep, even just for a brief moment while driving a vehicle? **(DO NOT READ LIST.)**

01 Yes ➔ **CONTINUE**
02 No
96 Don't drive/Don't have a license
98 Refused
99 Don't know

➔ **SKIP TO Q53**

IF YES (01) IN Q51, ASK Q52. OTHERWISE SKIP TO Q53.

52. How often do you nod off or fall asleep while driving a vehicle? Would you say…**(READ LIST.)**

05 Every day or almost every day,
04 3 to 4 days a week,
03 1 to 2 days a week,
02 1 to 2 days a month, or
01 Less often or never?
98 **DO NOT READ:** Refused
99 **DO NOT READ:** Don't know

SECTION 8: HEALTH -- ASK EVERYONE

53. What is your height without shoes? **(RECORD HEIGHT IN FEET AND INCHES)**

_____
(RECORD HEIGHT)

54. What is your weight without shoes? **(RECORD WEIGHT IN POUNDS BELOW. DO NOT ACCEPT RANGES)**

_____
(RECORD WEIGHT)
(COMPUTER WILL RECORD BMI (BODY MASS INDEX)

55. Do you now smoke every day, some days, or not at all? **(DO NOT READ LIST.)**

01 Every day
02 Some days
03 Not at all
98 Refused
99 Don't know

56. Have you ever been told by a doctor that you have any of the following medical conditions? **(READ LIST. RANDOMIZE.)**

	Yes	No	Refused	Don't know
a. Heart disease	01	02	98	99
b. Arthritis	01	02	98	99
c. Diabetes	01	02	98	99
d. Heartburn or GERD	01	02	98	99
e. Depression	01	02	98	99
f. Anxiety disorder such as panic disorder or post dramatic stress disorder	01	02	98	99
g. Lung disease	01	02	98	99
h. High blood pressure	01	02	98	99

SECTION 9: EMPLOYMENT -- ASK EVERYONE

57. What was your employment status over the past 3 months? Were you primarily…**(READ LIST. MULTIPLE RESPONSES ACCEPTED EXCEPT WITH 05, 06, AND 08.)**

01 Working more than one job,
02 Working full-time,
03 Working part-time,
➔ CONTINUE

04 A student,
05 A homemaker,
06 Unemployed,
07 Retired,
08 Disabled, or a
09 Volunteer?
95 **DO NOT READ:** Other **(SPECIFY):** _____
98 **DO NOT READ:** Refused
99 **DO NOT READ:** Don't know
➔ SKIP TO D1

IF "01-03" IN Q57, ASK Q58. OTHERWISE SKIP TO D1.

58. Thinking about the past 3 months, which of the following best describes your work schedule? Would you say that you worked…**(READ LIST.)**

    01 Regular day shifts,
    02 Regular evening shifts,
    03 Regular night shifts, or
    04 Rotating shifts?
    95 **DO NOT READ:** Other **(SPECIFY):** _____
    98 **DO NOT READ:** Refused
    99 **DO NOT READ:** Don't know

59. On average, how many total hours per week do you work at a job for which you are paid? **(RECORD NUMBER OF HOURS BELOW. DO NOT ACCEPT RANGES. RECORD 998 FOR REFUSED, 999 FOR DON'T KNOW AND 000 FOR NONE.)**

    _____
    (RECORD HOURS)

60. What is your occupation and for what type of company do you work? **(RECORD RESPONSES BELOW.)**

    _____ _____
    (OCCUPATION) (TYPE OF COMPANY)

SECTION 10: DEMOGRAPHICS -- ASK EVERYONE

These last few questions are for classification purposes only and will be kept strictly confidential.

D1. Would you consider yourself to be White, Black, Hispanic, or of some other racial or ethnic background? **(DO NOT READ LIST. MULTIPLE RESPONSES ACCEPTED.)**

    01 White
    02 Black/African-American
    03 Hispanic
    95 Other **(SPECIFY):**_____
    98 Refused

D2. What is your age? ___ **ENTER AGE AS 3 DIGITS (EX: AGE = 32, ENTER AS 032. RECORD 998 FOR REFUSED.)**

D3. How would you describe the area in which you live? Would you say…**(READ LIST.)**

01 Rural,
02 Urban, or
03 Suburban?
98 **DO NOT READ:** Refused
99 **DO NOT READ:** Don't know

READ TO EVERYONE

Those are all the questions I have. On behalf of the National Sleep Foundation, we would like to thank you very much for your cooperation. For quality control purposes, you may receive a follow-up phone call from my supervisor to verify that I have completed this interview. Can I please have your name or initials so they know who to ask for if they call back?

IF RESPONDENT ASKS FOR MORE INFORMATION ON THE NATIONAL SLEEP FOUNDATION, SAY:

For more information on the National Sleep Foundation, you can visit their Web site at www.sleepfoundation.org.

RECORD NAME AND CONFIRM PHONE NUMBER FOR SUPERVISOR VERIFICATION

M. National Survey of Children's Health, 2003

Relevant Question:

S7Q20 During the past week, on how many nights did **[CHILD]** get enough sleep for a child **[his/her]** age?

____NUMBER OF DAYS **[RANGE CHECK: 00-07]**

(96) DON'T KNOW
(97) REFUSED

HELP SCREEN (S7Q20): "Enough sleep" is whatever you define it as for this child.

N. National Survey of Early Childhood Health

Relevant Questions:

Section 3: Interactions with Health Care Providers

A3Q03 (13A-c)
Since **(CHILD)**'s birth, did **(his/her)** doctors or health providers talk with you about **(CHILD)**'s sleeping positions?

YES	1	**SKIP TO A3Q04**
NO	2	
DK	6	**SKIP TO A3Q04**
REFUSED	7	**SKIP TO A3Q04**

A3Q03_A (13A-c-iii)
Would a discussion of **(CHILD)**'s sleeping positions have been helpful to you?

YES	1
NO	2
DK	6
REFUSED	7

A3Q14 (13B-c)
(In the <u>last 12 months</u>/ since {his/her} birth), did **(CHILD)**'s doctors or health providers talk with you about **(his/her)** sleeping with a bottle?

YES	1	**SKIP TO A3Q15**
NO	2	
DK	6	**SKIP TO A3Q15**
REFUSED	7	**SKIP TO A3Q15**

A3Q14_A (13B-c-iii)
Would a discussion of **(CHILD)**'s sleeping with a bottle have been helpful to you?

YES	1
NO	2
CHILD DOES NOT USE A BOTTLE	3
DK	6
REFUSED	7

O. Nurses' Health Study

Relevant Questions:

Questions from the Nurses' Health Study are copyrighted and could not be included here. Included below is a list of relevant questions across the years of study implementation.

2001
Question 12
Question 13
Question 15
Question 42

2002
Question 2
Question 3

2004
Question 55

P. United Nations General Social Survey, Cycle 12: Time Use

Relevant Questions:

Exception 1:

##ax	**What time did you fall asleep[reference day-1] night?** This question is asked in order to measure the amount of sleep on a given night. This would otherwise be missed as the designated day begins only at 4:00 a.m. <00:00-23:59>

Exception 2:

##cx	**What time did you wake up ?** This question is asked in order to measure the amount of sleep on a given night. This would otherwise be missed as the designated day ends only at 4:00 a.m. <00:00-23:59> <x> Don't know <r> Refused

Part D2:

c)	**When you need more time, do you tend to cut back on your sleep?**
<1>	Yes
<3>	No
<x>	Don't know
<r>	Refused

Part F:

F49	**Why are you dissatisfied ?** [Mark all that apply]
<1>	Not enough time for family (include spouse/partner and children)
<2>	Spends too much time on job/main activity
<3>	Not enough time for other activities (exclude work or family related activities)
<4>	Cannot find suitable employment
<5>	Employment related reason(s) (exclude spending too much time on job)
<6>	Health reasons (include sleep disorders)
<7>	Family related reason(s) (exclude not enough time for family)
<8>	Other reason(s) Go to F49S
<x>	Don't know
<r>	Refused

Part L:

L25	**Do you regularly have trouble going to sleep or staying asleep?**
<1>	Yes
<3>	No
<r>	Refused

Q. U.S. Department of Labor, Bureau of Labor Statistics: National Longitudinal Survey

Relevant Questions:

"Time Use," Round 3:

YTIM-300D R34813.00

On a typical weekday, what time do you generally go to sleep? Enter Time: |__|__||__|__| AM/PM
Hr :: Min

Lead-In: YTIM-300C [Def]

YTIM-500

On a typical weekday, what are the main activities you participate in and/or places you go between the time you wake up and the time you go to sleep?

If nothing is entered, (Go to YTIM-1220)

Lead-In: YTIM-300D [Def]

"Health" (http://www.bls.gov/nls/79quex/r19/y79r19health.pdf):

Q11-H40CESD-1E
[R68981.00]

During the past week.... My sleep was restless.

0 Rarely/None of the time/1 Day
1 Some/A little of the time/1-2 Days
2 Occasionally/Moderate amount of the time/3-4 Days
3 Most/All of the time/5-7 Days

Lead-In: Q11-H40CESD-1D [Def]

Q11-H40CHRC-10bb
[R69070.00]

(Do you have any of the following health problems? (other than problems discussed earlier)) Frequent trouble sleeping?

1 YES
0 NO

Lead-In: Q11-H40CHRC-10aa [Def]

R. Department of Veterans Affairs Databases

Because sleep-related disorders must be searched by ICD9 codes, questions are not presented in this appendix. Data sets are described on the VA Information Resource Center (VIREC) Web site: http://www.virec.research.med.va.gov/.

S. National Hospital Discharge Survey

Because sleep-related disorders must be searched by ICD9 codes, questions are not presented in this appendix.

T. National Vital Statistics System

Because sleep-related disorders must be searched by ICD9 codes, questions are not presented in this appendix.

U. Women's Health Initiative

Relevant Questions:

WHI Baseline Variables
Category: **Lifestyle > Sleep**

F37 Did you have trouble sleeping

These next questions are about your sleep habits. Please mark one of the answers for each of the following questions. Pick the answer that best describes how often you experienced the situation in the past 4 weeks. Did you have trouble falling asleep?

Values		N	%
1	No, not in past 4 weeks	93,997	58.1%
2	Yes, less than once a week	29,725	18.4%
3	Yes 1 or 2 times a week	20,726	12.8%
4	Yes, 3 or 4 times a week	9,440	5.8%
5	Yes, 5 or more times a week	6,462	4.0%
.	Missing	1,447	0.9%
		161,797	

Source Form: 37

Usage Notes: none

F37 Did you nap during the day

These next questions are about your sleep habits. Please mark one of the answers for each of the following questions. Pick the answer that best describes how often you experienced the situation in the past 4 weeks. Did you nap during the day?

Values		N	%
1	No, not in past 4 weeks	76,061	47.0%
2	Yes, less than once a week	35,619	22.0%
3	Yes 1 or 2 times a week	27,761	17.2%
4	Yes, 3 or 4 times a week	13,689	8.5%
5	Yes, 5 or more times a week	7,335	4.5%
.	Missing	1,332	0.8%
		161,797	

Source Form: 37

Usage Notes: none

F37 Did you snore

These next questions are about your sleep habits. Please mark one of the answers for each of the following questions. Pick the answer that best describes how often you experienced the situation in the past 4 weeks. Did you snore?

Values		N	%
1	No, not in past 4 weeks	32,995	20.4%
2	Yes, less than once a week	7,589	4.7%
3	Yes 1 or 2 times a week	10,113	6.3%
4	Yes, 3 or 4 times a week	8,469	5.2%
5	Yes, 5 or more times a week	18,567	11.5%
9	Don't know	82,751	51.1%
.	Missing	1,313	0.8%
		161,797	

Source Form: 37

Usage Notes: none

WHI Baseline Variables
Category: **Lifestyle > Sleep**

F37 Did you wake up several times

These next questions are about your sleep habits. Please mark one of the answers for each of the following questions. Pick the answer that best describes how often you experienced the situation in the past 4 weeks. Did you wake up several times at night?

Values		N	%
1	No, not in past 4 weeks	35,194	21.8%
2	Yes, less than once a week	27,334	16.9%
3	Yes 1 or 2 times a week	34,153	21.1%
4	Yes, 3 or 4 times a week	28,713	17.7%
5	Yes, 5 or more times a week	34,961	21.6%
.	Missing	1,442	0.9%
		161,797	

Source Form: 37

Usage Notes: none

F37 How many hours of sleep

About how many hours of sleep did you get on a typical night during the past 4 weeks?

Values		N	%
1	5 or less hours	13,594	8.4%
2	6 hours	44,364	27.4%
3	7 hours	60,241	37.2%
4	8 hours	35,726	22.1%
5	9 hours	6,205	3.8%
6	10 or more hours	839	0.5%
.	Missing	828	0.5%
		161,797	

Source Form: 37

Usage Notes: none

F37 Typical nights sleep

Overall, was your typical night's sleep during the past 4 weeks:

Values		N	%
1	Very restless	3,629	2.2%
2	Restless	22,732	14.0%
3	Average quality	67,627	41.8%
4	Sound or restful	46,161	28.5%
5	Very sound or restful	20,736	12.8%
.	Missing	912	0.6%
		161,797	

Source Form: 37

Usage Notes: none

WHI Baseline Variables
Category: **Lifestyle > Sleep**

F37 Your sleep was restless

These are questions about your feelings during the past week. For each of the statements, please indicate the choice that tells how often you felt that way. Your sleep was restless

Values		N	%
0	Rarely or none of the time	69,961	43.2%
1	Some or a little of the time	58,053	35.9%
2	Occasionally or a moderate amount	21,566	13.3%
3	Most or all of the time	10,729	6.6%
.	Missing	1,488	0.9%
		161,797	

Source Form: 37

Usage Notes: none

F37 fall asleep during quiet activity

These next questions are about your sleep habits. Please mark one of the answers for each of the following questions. Pick the answer that best describes how often you experienced the situation in the past 4 weeks. Did you fall asleep during quiet activities like reading, watching TV, or riding in a car?

Values		N	%
1	No, not in past 4 weeks	39,841	24.6%
2	Yes, less than once a week	36,279	22.4%
3	Yes 1 or 2 times a week	41,822	25.8%
4	Yes, 3 or 4 times a week	26,125	16.1%
5	Yes, 5 or more times a week	16,554	10.2%
.	Missing	1,176	0.7%
		161,797	

Source Form: 37

Usage Notes: none

F37 take medication for sleep

These next questions are about your sleep habits. Please mark one of the answers for each of the following questions. Pick the answer that best describes how often you experienced the situation in the past 4 weeks. Did you take any kind of medication or alcohol at bedtime to help you sleep?

Values		N	%
1	No, not in past 4 weeks	122,162	75.5%
2	Yes, less than once a week	14,867	9.2%
3	Yes 1 or 2 times a week	8,969	5.5%
4	Yes, 3 or 4 times a week	4,565	2.8%
5	Yes, 5 or more times a week	10,131	6.3%
.	Missing	1,103	0.7%
		161,797	

Source Form: 37

Usage Notes: none

WHI Baseline Variables
Category: **Lifestyle > Sleep**

F37 trouble getting back to sleep

These next questions are about your sleep habits. Please mark one of the answers for each of the following questions. Pick the answer that best describes how often you experienced the situation in the past 4 weeks. Did you have trouble getting back to sleep after you woke up too early?

Values		N	%
1	No, not in past 4 weeks	77,725	48.0%
2	Yes, less than once a week	32,296	20.0%
3	Yes 1 or 2 times a week	26,864	16.6%
4	Yes, 3 or 4 times a week	14,163	8.8%
5	Yes, 5 or more times a week	9,358	5.8%
.	Missing	1,391	0.9%
		161,797	

Source Form: 37

Usage Notes: none

F37 wake up earlier than planned

These next questions are about your sleep habits. Please mark one of the answers for each of the following questions. Pick the answer that best describes how often you experienced the situation in the past 4 weeks. Did you wake up earlier than you planned

Values		N	%
1	No, not in past 4 weeks	66,246	40.9%
2	Yes, less than once a week	34,561	21.4%
3	Yes 1 or 2 times a week	30,607	18.9%
4	Yes, 3 or 4 times a week	17,388	10.7%
5	Yes, 5 or more times a week	11,638	7.2%
.	Missing	1,357	0.8%
		161,797	

Source Form: 37

Usage Notes: none

F42 Number of hours spent sleeping

During a usual day and night, about how many hours do you spend sleeping or lying down with your feet up? Be sure to include the time you spend sleeping or trying to sleep at night, resting or napping, and lying down watching TV.

Values		N	%
1	Less than 4 hours	5,970	6.4%
2	4-5 hours	2,905	3.1%
3	6-7 hours	25,445	27.2%
4	8-9 hours	42,332	45.2%
5	10-11 hours	12,733	13.6%
6	12-13 hours	2,739	2.9%
7	14-15 hours	585	0.6%
8	16 or more hours	277	0.3%
.	Missing	620	0.7%
		93,606	

Source Form: 42

Usage Notes: none

V. Sleep Heart Health Study (SHHS)

Relevant Questions:

Keyed: ( )

SLEEP HEART HEALTH

SLEEP HEART HEALTH STUDY

HEALTH INTERVIEW

Field Site ID: __ __
Participant ID#: _____
Alpha Code: __ __ __ __ __
Date form initiated: __ __ – __ __ – 2 0 0 __ (month / day / year)
Visit ID Code: F 0 2
Form & revision: H I 2
Form sequence: __ __

A. Past history

1. Has a doctor ever told you that you have the following?

	YES	NO	Don't know
a. Emphysema	☐ 1	☐ 0	☐ 8
b. Chronic bronchitis	☐ 1	☐ 0	☐ 8
c. COPD (chronic obstructive pulmonary disease)	☐ 1	☐ 0	☐ 8
d. Asthma	☐ 1	☐ 0	☐ 8

e. Do you still have asthma?

YES ☐ 1 NO ☐ 0

2. During the last two weeks, did you take any aspirin or aspirin-containing medicines such as Bufferin, Anacin, or Ascriptin?

YES ☐ 1 NO ☐ 0

a. If "Yes," on how many days during the last two weeks did you take this medicine?

_____ _____ (number of days)

B. Last night and today

The next few questions I have are about your sleep last night.

3. What time did you go to sleep last night?

___ ___ : ___ ___ ☐ 1 A.M. ☐ 2 P.M.
(Midnight is 12:00 A.M.)

4. How long did you sleep last night?

_____ _____ hours _____ _____ minutes

5. How well did you sleep last night?

☐ 1 Much worse than usual
☐ 2 Somewhat worse than usual
☐ 3 As well as usual
☐ 4 A little better than usual
☐ 5 Much better than usual

6. If you took any naps today, what is the total time you slept during the naps? *(use "00" minutes for no naps.)*

_____ _____ hours _____ _____ minutes

7. How stressful was your day today? Was it: *(check one.)*

☐ 1 A typical day
☐ 2 Less stressful than usual
☐ 3 More stressful than usual

SHHS Form HI
Revision 2 (16 Nov 00)
Health Interview
1 of 3

C. Restless legs

8. In the past year, while SITTING OR LYING DOWN, have you had any of the following symptoms?

	YES	NO	Don't know
a. An urge to move your legs	☐ 1	☐ 0	☐ 8
b. Unpleasant or uncomfortable feelings in your legs	☐ 1	☐ 0	☐ 8

If answer is "No" or "Don't Know" to both, go to question 16.

Questions #9-10 are about your MOST FREQUENT symptom you checked as yes in item #8.

9. How often do you get this symptom? *(check the one best answer)*

- ☐ 1 Less than once a month
- ☐ 2 About once a month
- ☐ 3 2-4 days a month
- ☐ 4 5-15 days a month
- ☐ 5 Most days (16-23 days a month)
- ☐ 6 Daily (6 days a week or more)

10. How bothersome or troublesome is this symptom? *(answer based on most frequent symptom)* **Does it bother you:** *(check one)*

- ☐ 1 Hardly at all
- ☐ 2 A little
- ☐ 3 Moderately
- ☐ 4 A lot
- ☐ 5 Extremely

Questions #11-15 refer to all symptoms you checked as present in item #8.

11. These symptoms are most likely to occur when you are *(check the one best answer):*

- ☐ 1 Resting, sitting or lying down
- ☐ 2 Exercising or just stopped exercising
- ☐ 3 Standing or walking
- ☐ 4 Having a leg cramp or "charlie horse"
- ☐ 8 Don't know

12. Are they worse when you are sitting or lying down than when you are moving around or walking?

YES	NO	Don't know
☐ 1	☐ 0	☐ 8

13. Do the symptoms improve if you get up and start walking?

YES	NO	Don't know
☐ 1	☐ 0	☐ 8

14. What time of day do they occur? *(check the one best answer):*

- ☐ 1 Daytime only (before 6 PM)
- ☐ 2 Bedtime only
- ☐ 3 Evening or nighttime only (after 6 PM)
- ☐ 4 Both day and night

a. If both day and night, do they get worse at night?

YES	NO	Don't know
☐ 1	☐ 0	☐ 8

SHHS Form HI
Revision 2 (16 Nov 00) Health Interview 2 of 3

15. How old were you when you first noticed these symptoms? ***(write in "D" if Don't know)***

_____ _____ age in years (approximate OK)

16. Has a doctor ever told you that you have the restless leg syndrome?

YES	NO	Don't know
☐ 1	☐ 0	☐ 8

D. Administrative information

Field Site Use Only

17. Interviewer administered in:

- ☐ 1 English
- ☐ 2 Spanish
- ☐ 3 Lakota
- ☐ 4 Pima
- ☐ 5 Other, specify:_____
- ☐ 6 Unknown

18. Interviewer or Reviewer: ____ ____ ____

19. Date: __ __ – __ __ – 2 0 0 __
month day year

20. Comments:

_____

_____

_____

SHHS Form HI
Revision 2 (16 Nov 00) Health Interview 3 of 3

W. National Ambulatory Medical Care Survey

Because sleep-related disorders must be searched by ICD9 Codes, questions are not presented in this appendix.

Appendix II.
Relevant Questions From Selected Large-Sample Sleep Studies

Table of Contents

A. Corporate British Health Questionnaire....II–5
B. Chronic Fatigue Syndrome and Sleep Assessment....II–13
C. Daytime Sleepiness and Hyperactive Children....II–15
D. Nursing Home Resident Assessment and Care Screening - MDS....II–16
E. Older Adults and Arthritis....II–16
F. Pediatric Sleep Medicine Survey....II–17
G. Reduction in Tinnitus Severity....II–23

A. Corporate British Health Questionnaire

Sample Characteristics: Forty-one percent male, 59 percent female; average age 38.1 years; 34 percent single, 59 percent married; 7 percent separated/widowed; 47 percent worked less than 40 hours per week, 41 percent worked 40–50 hours per week; 27 percent earned 10–20 pounds per year, 30 percent earned 20–30,000 pounds per year; 49 percent held junior-level positions, 40 percent held middle-level positions, and 11 percent held senior positions.

Relevant Questions:

Health & Well-Being Questionnaire

The following questionnaire was completed online by all study participants. Each question had explanatory text associated with it that gave reasons for asking the question and appropriate examples to aid understanding. The numbers in square brackets represent the "score" attributed to the possible responses to each question (full scoring algorithm given at end of document).

Q1

Background details

Male ☐ Female ☐

Height_____ Weight_____

Q2

Do you have, or are you being treated for, any of the following conditions?

Please tick all that apply

☐ Anxiety

☐ Arthritis

☐ Asthma, bronchitis or emphysema

☐ Back or spinal problems

☐ Cancer

☐ Depression or bipolar disorder

☐ Diabetes

☐ Heart disease

☐ High blood pressure

☐ High cholesterol

☐ Migraine Headaches

☐ Sinusitis or allergic rhinitis (hayfever)

☐ Any other serious health problem for which you are receiving medical treatment

Q3

On average how many units of alcohol do you consume per week

☐	I do not drink alcohol	[100]
☐	0 to 7	[100]
☐	8 to 14	[100]
☐	15 to 20	[100 if male] [0 if female]
☐	21 or more	[0]

Q4

Do you smoke every day

☐	No	[100]
☐	Yes	[0]

Q5

How much bodily pain have you experienced during the last 3 months?

☐	None	[100]
☐	Mild	[75]
☐	Moderate	[50]
☐	Severe	[25]
☐	Very Severe	[0]

Q6

Which of the following five statements best describes your usual level of physical activity?

☐ I avoid exerting myself whenever possible. I use the lift / elevator rather than taking the stairs and drive rather than walk. [0]

☐ I often walk places and occasionally exercise enough to cause myself to breathe more heavily than usual, but do this for less than 30 minutes per day [0]

☐ I take regular moderate intensity activity (such as cycling, brisk walking, playing golf or gardening) that causes me to breathe more heavily than usual and sweat. On average I do this for 30 minutes a day on most days of the week [50]

☐ I regularly do high intensity physical activity, such as running, swimming lengths or gym work. I do this for between 30 and 60 minutes a week [75]

☐ I regularly do high intensity physical activity, such as running, swimming lengths or gym work. I do this for more than an hour a week [100]

Q7

How many portions of fibre do you eat a day?

☐	1 or none	[0]
☐	2 or 3	[25]
☐	3 or 4	[50]
☐	5	[75]
☐	6 or more	[100]

Q8

How often do you eat a portion of fruit or vegetables?

☐	Rarely or never	[0]
☐	Occasionally, less than once per day	[25]
☐	1 to 2 times per day	[50]
☐	3 to 4 times per day	[75]
☐	5 or more times a day	[100]

Q9

When choosing foods for your meal, do you usually select high-fat or low-fat foods?

☐	I choose high-fat foods nearly all the time	[0]
☐	I choose high-fat foods most of the time	[25]
☐	I choose both high- and low-fat foods equally as often	[50]
☐	I choose low-fat foods most of the time	[75]
☐	I choose low fat foods all of the time	[100]

Q10

On a scale of 1 through to 5 how satisfied are you with your current job?

1 = Not very satisfied
2 = A little satisfied
3 = Moderately satisfied
4 = Satisfied
5 = Very satisfied

1	2	3	4	5
☐	☐	☐	☐	☐
[0]	[25]	[50]	[75]	[100]

Please rate the following four statements on the 1 through to 5 scale, where

1 = Not at all
2 = A little
3 = A moderately amount
4 = Most of the time
5 = All of the time

Q11

How much of the time during the last 3 months have you felt calm and peaceful?

1	2	3	4	5
☐	☐	☐	☐	☐
[0]	[25]	[50]	[75]	[100]

Q12

How much of the time during the last 3 months did you have a lot of energy?

1	2	3	4	5
☐	☐	☐	☐	☐
[0]	[25]	[50]	[75]	[100]

Q13

How much of the time during the last 3 months have you felt depressed or sad?

1	2	3	4	5
☐	☐	☐	☐	☐
[0]	[25]	[50]	[75]	[100]

Q14

How much of the time during the last 3 months have you felt happy?

1	2	3	4	5
☐	☐	☐	☐	☐
[0]	[25]	[50]	[75]	[100]

Q15

How do you feel about the coming six months?

☐ Very concerned and worried, the coming six months are going to be very difficult for me and I'm not sure how well I'll cope [0]

☐ Moderately concerned and worried, the coming six months are going to be difficult, but I'm sure I'll cope [25]

☐ Neither concerned nor optimistic, the coming six months are going to be pretty much the same as usual for me [50]

☐ Moderately optimistic, I think the coming six months are going to be good for me [75]

☐ Very optimistic. I am looking forward to the coming six months, everything is going right for me [100]

Q16

During the last 3 months how much of the time have you felt overwhelmed with pressure or stress from responsibilities, circumstances or relationships?

1 = Not at all
2 = A little of the time
3 = A moderate amount of the time
4 = Most of the time
5 = All of the time

1	2	3	4	5
☐	☐	☐	☐	☐
[0]	[25]	[50]	[75]	[100]

Q17

On average how many hours of sleep do you get a night?

☐	5 or less hours	[0]
☐	More than 5 hours but less than 7 hours	[50]
☐	7 to 8 hours	[100]
☐	More than 8 hours	[100]

Q18

In general how happy are you with the amount and quality of sleep that you get?

☐	Very happy, I sleep well	[100]
☐	Mostly happy, I usually sleep well but occasionally I have difficulties	[75]
☐	A little unhappy, I often have sleep difficulties	[25]
☐	Very unhappy, I regularly have sleep difficulties and usually sleep very poorly	[0]

Q19

How refreshed and restored do you feel ½ an hour after getting up in the morning?

☐	Completely refreshed and restored	[100]
☐	A little tired but generally refreshed	[75]
☐	Rather un-refreshed, but able to function	[25]
☐	Completely exhausted and un-refreshed.	[0]

Consider your work responsibilities and how effective you are in accomplishing them. Please answer the following question on the 1 though to 5 scale.

Q20

How effective in your work have you been over the last 3 months?

1 = Not effective
2 = A little effective
3 = Moderately effective
4 = Quite effective
5 = Highly effective

1	2	3	4	5
☐	☐	☐	☐	☐
[0]	[25]	[50]	[75]	[100]

The following additional background / demographic information was collected either from the individual or from the human resources department:

a. Date of birth

b. Number of sickness absence days in the last 6 months

Scoring of Questionnaire:

Medical Health Status:

Number of medical conditions	Score
0	100
1	75
2	50
3	25
4+	0

Bodily Pain

Scored according to answer given to Q5

Physical Activity

Scored according to answer given to Q6

Nutrition

Sum of scores from Qs 7, 8 and 9 divided by 3

Sleep

Sum of scores from Qs 17, 18 and 19 divided by 3

Stress

Sum of scores from Qs 11, 12,13,14,15 and 16 divided by 6

Job Satisfaction

Scored according to answer to Q10

Smoking

Scored according to answer to Q4

Alcohol

Scored according to answer to Q3

Body Mass Index

Body Mass Index	Score
<18.5	50
18.5 to <25	100
25 to <30	25
≥ 30	0

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B. Chronic Fatigue Syndrome and Sleep Assessment

Relevant Questions:

The Sleep Assessment Questionnaire©

Patient Name: _____ Male ☐ Female ☐

Today's Date: ☐ ☐ ☐ (Day Month Year)

Date of Birth: ☐ ☐ ☐ (Day Month Year)

Height: ☐ inches or ☐ cm

Weight: ☐ lbs. or ☐ kg

PLEASE ANSWER EACH QUESTION BY CHECKING THE **ONE ANSWER** THAT FITS BEST

Over the past **month**, how often have you experienced the following……..

	Never	**Rarely**	**Some times**	**Often**	**Always**	**Don't Know**
1. Difficulty falling asleep?						
2. Sleeping for less than 5 hours?						
3. Sleeping more than 9 hours?						
4. Repeated awakenings during your sleep?						
5. Loud snoring?						
6. Interruptions to your breathing during sleep?						
7. Restlessness during your sleep (e.g. move your legs or kick)?						
8. Nightmares or waking up frightened or crying out loud?						
9. Waking up before you want to (i.e., getting less sleep than you need)?						
10. Waking up NOT feeling refreshed or thoroughly rested?						
11. Waking up with aches or pains or stiffness?						

12. Falling asleep while sitting (e.g., reading, watching t.v.)?						
13. Falling asleep while doing something (e.g., driving, talking to people)?						
14. Working shifts?						
15. Working night shifts?						
16. Irregular bed time and/or wakeup time during work or weekdays?						
17. Taking medication for sleep or nervousness?						

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For further information on the Sleep Assessment Questionnaire© contact Dr. Harvey Moldofsky, Sleep Disorders Clinic, Centre for Sleep and Chronobiology, 340 College Street, Suite 580, Toronto, Ontario, Canada, MST 3A9. Phone (416) 603-9531, FAX (416) 603-2388, website: www.sleepmed.to

C. Daytime Sleepiness and Hyperactive Children

Relevant Questions:

APPENDIX 2: CONNERS ABBREVIATED SYMPTOM QUESTIONNAIRE

Observation	Not at All	Just a Little	Pretty Much	Very Much
1. Restless or overactive				
2. Excitable, impulsive				
3. Disturbs other children				
4. Fails to finish things he/she starts–short attention span				
5. Constantly fidgeting				
6. Inattentive, easily distracted				
7. Demands must be met immediately–easily frustrated				
8. Cries often and easily				
9. Mood changes quickly and drastically				
10. Temper outbursts, explosive and unpredictable behavior				

Sample Characteristics:

TABLE 1. Demographic Data of Study Population

	Patients With S-SDB	Controls
N	108	72
Age, y, mean ± SD (range)	7 ± 4 (2–16)	8 ± 4 (2–17)
Female gender, *n* (%)	58 (55)	43 (60)
Race, *n* (%)		
White	26 (24)	26 (36)
Black	79 (73)	46 (64)
Other	3 (3)	0 (0)
Private insurance, *n* (%)	37 (34)	28 (39)

There was no statistical difference between patients with S-SDB and control subjects on the basis of age, gender, race, and type of insurance. The type of insurance was used as a surrogate measure of socioeconomic status.

D. Nursing Home Resident Assessment and Care Screening – Minimum Data Set

Relevant Section:

Section E. Mood and Behavior Patterns

1.	INDICATORS OF DEPRES-SION, ANXIETY, SAD MOOD	(***Code for indicators observed in last 30 days, irrespective of the assumed cause***) 0. Indicator not exhibited in last 30 days 1. Indicator of this type exhibited up to five days a week 2. Indicator of this type exhibited daily or almost daily (6, 7 days a week)	
		VERBAL EXPRESSIONS OF DISTRESS	
		a. Resident made negative statements—e.g., "*Nothing matters; Would rather be dead; What's the use; Regrets having lived so long; Let me die*"	
		b. Repetitive questions—e.g., "*Where do I go; What do I do?*"	
		c. Repetitive verbalizations—e.g., calling out for help, ("*God help me*")	
		d. Persistent anger with self or others—e.g., easily annoyed, anger at placement in nursing home; anger at care received	
		e. Self deprecation—e.g., "*I am nothing; I am of no use to anyone*"	
		f. Expressions of what appear to be unrealistic fears—e.g., fear of being abandoned, left alone, being with others	
		g. Recurrent statements that something terrible is about to happen—e.g., believes he or she is about to die, have a heart attack	
		h. Repetitive health complaints—e.g., persistently seeks medical attention, obsessive concern with body functions	
		i. Repetitive anxious complaints/concerns (non-health related) e.g., persistently seeks attention/reassurance regarding schedules, meals, laundry, clothing, relationship issues	
		SLEEP-CYCLE ISSUES	
		j. Unpleasant mood in morning	
		k. Insomnia/change in usual sleep pattern	

E. Older Adults and Arthritis

Health-Related Quality of life Questionnaire

Appendix A. CDC HRQOL Items

1. Would you say that in general your health is: Excellent, Very good, Good, Fair, or Poor?
2. Now thinking about your physical health, which includes physical illness and injury, for how many days during the past 30 days was your physical health not good?
3. Now thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?
4. During the past 30 days, for about how many days did poor physical or mental health keep you from doing your usual activities, such as self-care, work, or recreation?
5. During the past 30 days, for about how many days did pain make it hard for you to do your usual activities, such as self-care, work, or recreation?
6. During the past 30 days, for about how many days have you felt you did not get enough rest or sleep?
7. During the past 30 days, for about how many days have you felt very healthy and full of energy?
8. Are you limited in any way in any activities because of any impairment or health problem?
9. Because of any impairment or health problem, do you need the help of other persons with your personal care needs, such as eating, bathing, dressing, or getting around the house?

F. Pediatric Sleep Medicine Survey

Relevant Questions:

PEDIATRIC SLEEP SURVEY

I. The purpose of this section of the survey is to gather information about how familiar practicing physicians are with sleep and sleep disorders in children and adolescents. Your answers are anonymous. This is not a test.

Please circle the correct response -True/False/Don't Know

1) There is a physiologically-based **increase** in daytime alertness in adolescents around the time of puberty.	True	False	Don't Know
2) Children with delayed sleep phase ("Night Owls") may present with bedtime resistance.	True	False	Don't Know
3) The incidence of Obstructive Sleep Apnea Syndrome (OSAS) in pre-schoolers is less than 1%.	True	False	Don't Know
4) Night terrors and sleepwalking often have a familial component.	True	False	Don't Know
5) Please read the following statements in regards to **Narcolepsy** in children and circle the correct response for each item:			
a. Does not occur in pre-pubertal children	True	False	Don't Know
b. Requires an overnight sleep study and Multiple Sleep Latency Test (MSLT) to diagnose	True	False	Don't Know
c. Psychostimulants are usually the treatment of choice	True	False	Don't Know
6) Bright light phototherapy with a light box may be helpful for children with a delayed sleep phase.	True	False	Don't Know
7) Children with ADHD seldom have sleep onset difficulties unless they are on psychostimulant medication.	True	False	Don't Know
8) It is normal for school-aged children to take naps up to several times a week.	True	False	Don't Know
9) Breast-fed babies usually sleep through the night at an earlier age than bottle-fed babies.	True	False	Don't Know
10) Hyperactivity is a common presenting complaint in pediatric OSAS.	True	False	Don't Know
11) Amnesia for the episode is not helpful in distinguishing night terrors from nightmares.	True	False	Don't Know
12) Children with severe developmental delays have an increased risk of developing sleep schedule disturbances.	True	False	Don't Know
13) Average 24-hour total sleep duration for a 3-year old is about 8 hours.	True	False	Don't Know
14) Health care providers should **not** recommend temporary establishment of a later bedtime as an intervention for a child with difficulty falling asleep.	True	False	Don't Know
15) No combination of clinical symptom severity and physical findings reliably predicts disease severity in children with OSAS.	True	False	Don't Know
16) Nocturnal bedwetting occurs almost exclusively during deep or slow-wave sleep.	True	False	Don't Know

17) School avoidance makes a sleep phase delay in adolescents more difficult to treat. True False Don't Know

18) It is normal for young children to awaken briefly during the night at the end of a sleep cycle (every 60-90 minutes). True False Don't Know

19) "Learned Hunger" resulting from frequent night feedings can lead to increased nocturnal awakenings in infants. True False Don't Know

20) Children from which of the following groups are at increased risk for **Obstructive Sleep Apnea Syndrome** (Please circle the correct response for each item):

a. Prader-Willi Syndrome True False Don't Know

b. Down Syndrome True False Don't Know

c. Repaired Cleft Palate True False Don't Know

d. Achondroplasia True False Don't Know

21) Bruxism (teeth grinding) is uncommon in children. True False Don't Know

22) Head banging in infants at bedtime is usually associated with developmental delay. True False Don't Know

23) Please read the following statements in regards to **Restless Legs Syndrome/ Periodic Leg Movement Disorder** and circle the correct response for each item:

a. Does not occur in children under 12 years True False Don't Know

b. May be linked to symptoms of Attention Deficit Hyperactivity Disorder True False Don't Know

c. May be cause of "growing pains" in children True False Don't Know

II. The purpose of this next section of the survey is to assess how physicians screen, evaluate, and treat childhood sleep disorders in their own practices. Please answer based on <u>what you actually do</u>, rather than what you think you should do for the following:

A. **SCREENING** for sleep problems: - In the context of a **Well Child Exam**, which sleep history questions do you include **greater than 75% of the time** in the following age groups? (Please check all that apply):

	INFANTS (0-1 YRS)	TODDLERS/ PRE-SCHOOL (2-4 YRS)	SCHOOL-AGED (5-12 YRS)	ADOLESCENTS (13+ YRS)
a. do not screen for sleep problems in this age group				
b. generally ask single question **only** about general sleep problems				
c. usual bedtime				
d. usual wake time				
e. usual sleep amount				
f. naps				
g. regularity of sleep-wake schedule				
h. co-sleeping				
i. bedtime resistance				
j. sleep onset delay				
k. night wakings				
l. nighttime fears				
m. sleepwalking				
n. night terrors				
o. nightmares				
p. bedwetting				
q. teeth grinding				
r. frequent leg kicking or twitching during sleep				
s. snoring				
t. breathing pauses				
u. restless sleep				
v. difficulty am waking				
w. daytime sleepiness				
x. daytime behavior problems				
y. family history of sleep problems				
z. question child about sleep habits				

2) If you **do not** routinely screen for sleep problems, please indicate the reason(s). (Check all that apply):

- ☐ Sleep problems not important
- ☐ Takes too much time
- ☐ Lack of reimbursement
- ☐ Not necessary because of low incidence of problems
- ☐ Takes time away from asking about other health concerns
- ☐ Do not feel comfortable asking questions about sleep
- ☐ Do not feel knowledgeable about sleep problems
- ☐ Sleep problems generally not treatable
- ☐ Parent will indicate if there is a problem anyway, even without screening
- ☐ Other (Please explain): _____

B. **EVALUATION** of sleep disorders: For the following **presenting sleep complaints**, indicate how often **you do the following** in your practice: (Please circle the appropriate response:)

1 = NEVER/RARELY
2 = OCCASIONALLY
3 = ABOUT HALF
4 = OFTEN
5 = ALWAYS

1) In toddlers with **frequent night wakings**, focus on the method of falling asleep.	1	2	3	4	5
2) In a pre-schooler with **bedtime resistance**, ask about parental disciplinary style.	1	2	3	4	5
3) In school-aged children with **secondary enuresis**, inquire about a history of snoring.	1	2	3	4	5
4) Ask about the timing of the night wakings in evaluating a child for **parasomnias**.	1	2	3	4	5
5) Routinely inquire about symptoms of cataplexy in adolescents with profound **daytime sleepiness**.	1	2	3	4	5

6) Of the following options for further **evaluation** of a patient in whom you suspect **Obstructive Sleep Apnea** on clinical grounds:

a. obtain x-rays, EKG, or lab tests:	1	2	3	4	5
b. refer to a sleep subspecialist or sleep clinic for evaluation:	1	2	3	4	5
c. refer for an in-hospital overnight sleep study:	1	2	3	4	5
d. refer directly to an otolaryngologist	1	2	3	4	5

C. **TREATMENT** of sleep disorders: In the treatment of the following sleep disorders, indicate how often **you do the following** in your practice (please circle the appropriate response):

1) **Frequent night wakings** in a 14-month old who is routinely rocked to sleep at bedtime:

a. suggest co-sleeping with parents	1	2	3	4	5
b. advise increasing the level of parental intervention at bedtime	1	2	3	4	5
c. advise gradually increasing time intervals between "checking on" child ("Ferber Method")	1	2	3	4	5
d. advise parents that problem will resolve without intervention	1	2	3	4	5

2) **Bedtime resistance** in a pre-schooler due to sudden onset of nighttime fears:

a. advise ignoring fears and setting firm limits at bedtime	1	2	3	4	5
b. suggest transitional object	1	2	3	4	5

c. encourage bedtime television viewing "to relax" child	1	2	3	4	5
d. utilize positive reinforcement (sticker chart) for staying in bed	1	2	3	4	5
3) Weekly **night terrors** in a 7-year old:					
a. suggest diphenhydramine (Benadryl) at bedtime	1	2	3	4	5
b. advise parents about safety issues, but basically just reassure	1	2	3	4	5
c. suggest psychological evaluation for child	1	2	3	4	5
d. encourage regular sleep-wake schedule	1	2	3	4	5
4) **Insomnia** in an adolescent due to poor sleep habits:					
a. suggest trial of melatonin	1	2	3	4	5
b. encourage "catch-up" sleep on weekends	1	2	3	4	5
c. prescribe hypnotics at bedtime	1	2	3	4	5
d. suggest maintaining a similar sleep-wake schedule on weekdays and weekends	1	2	3	4	5
e. discourage using bed for activities other than sleep	1	2	3	4	5
5) Of the following **treatment** options for a patient in whom you suspect **Obstructive Sleep Apnea** on clinical grounds:					
a. If tonsils are enlarged, refer directly to an otolaryngologist for adenotonsillectomy	1	2	3	4	5
b. If obese, refer to a nutritionist, or weight loss program	1	2	3	4	5
c. Prescribe nasal steroids if adenoidal hypertrophy is present	1	2	3	4	5
d. Refer for Continuous Positive Airway Pressure (CPAP)	1	2	3	4	5
e. Refer to orthodontist for oral appliance	1	2	3	4	5
f. Clinical observation only	1	2	3	4	5

III. This final section of the survey asks you for your opinion about several different aspects of sleep disorders in children.

Please rate the following statements, on a scale of 1 (not important) to 3 (somewhat important) to 5 (very important):

A. The **impact** of sleep problems on children's: (Please mark an "X" on the appropriate response:)

	Not Important		Somewhat Important		Very Important
1) general health	1	2	3	4	5
2) mood and behavior	1	2	3	4	5
3) academic performance	1	2	3	4	5
4) parental stress	1	2	3	4	5
5) non-intentional injury rates (falls, burns, etc.)	1	2	3	4	5

B. The **importance** of the following sleep-related public health issues:

	Not Important		Somewhat Important		Very Important
1) educating adolescents about drowsy driving	1	2	3	4	5
2) delaying high school start times	1	2	3	4	5
3) educating school personnel about children's sleep	1	2	3	4	5

Please rate the following on a scale of 1 (not confident) to 3 (somewhat confident) to 5 (very confident): (Please mark an "X" on the appropriate response)

	Not Confident		Somewhat Confident		Very Confident
C. Your ability to **screen** children for sleep problems	1	2	3	4	5
D. Your ability to **evaluate** children for sleep problems	1	2	3	4	5
E. Your ability to **manage** children with sleep problems	1	2	3	4	5

Please estimate the following: (Circle one)

F. **Overall** percentage of patients in your practice with **sleep problems**: 0-25% 26-50% 51-75% 76-100%

G. Percentage of patients in your practice with **sleep problems** in the **following age groups**: (Circle one)

1) 0-2 years	0-25%	26-50%	51-75%	76-100%
2) 3-6 years	0-25%	26-50%	51-75%	76-100%
3) 7-12 years	0-25%	26-50%	51-75%	76-100%
4) 13+ years	0-25%	26-50%	51-75%	76-100%

THANK YOU VERY MUCH FOR YOUR TIME!

If you would like assistance or consultation regarding any of your pediatric patients' sleep problems or would like to set up an appointment for a patient, please call us at the Pediatric Sleep Disorders Clinic, Hasbro Children's Hospital, (401) 444-8815.

G. Reduction in Tinnitus Severity

Relevant Questions:

Tinnitus Severity Survey

DIRECTIONS: For the questions below, please CIRCLE the number that best describes you

		Never	Rarely	Sometimes	Usually	Always
Does your tinnitus						
1.	Make you feel irritable or nervous	1	2	3	4	5
2.	Make you feel tired or stressed	1	2	3	4	5
3.	Make it difficult for you to relax	1	2	3	4	5
4.	Make it uncomfortable to be in a quiet room	1	2	3	4	5
5.	Make it difficult to concentrate	1	2	3	4	5
6.	Make it harder to interact pleasantly with others	1	2	3	4	5
7.	Interfere with your required activities (Work, home, care, or other responsibilities)	1	2	3	4	5
8.	Interfere with your social activities or other things you do in your leisure time	1	2	3	4	5
9.	Interfere with your overall enjoyment of life	1	2	3	4	5

10. Does your tinnitus interfere with sleep?
No 1
Yes, sometimes 2
Yes, often 3

11. How much of an effort is it for you to ignore tinnitus when it is present?
Can easily ignore it 1
Can ignore it with some effort . . 2
It takes considerable effort 3
Can never ignore it 4

12. How much discomfort do you usually experience when your tinnitus is present?
No discomfort 1
Mild discomfort 2
Moderate discomfort 3
A great deal of discomfort . . 4

On the scale below, please CIRCLE the number that best describes the loudness of your usual tinnitus

---

1 2 3 4 5 6 7 8 9 10

Very quiet Intermediate

Appendix III.
Relevant Questions From Sleep Scales and Questionnaires

Table of Contents

A. A.P.N.E.A. Net: The Apnea Patient's News, Education & Awareness Network—Sleep Apnea Questionnaire III–5

B. Epworth Sleepiness Scale III–7

C. Exempla Healthcare Sleep Disorders Laboratory: Patient Education and Screening Questionnaire III–9

D. Infant Screening Questionnaire III–10

E. Leeds Sleep Evaluation Questionnaire III–11

F. Maternal Child Supervision Questionnaire, 1961 ..... III–13

G. Parental Interactive Bedtime Behavior Scale III–16

H. Pediatric Sleep Questionnaire III–18

I. Sinai Hospital Sleep Disorder Assessment Questionnaire III–27

J. Sleep Apnea—The Phantom of the Night Questionnaire III–29

K. Pittsburgh Sleep Quality Index III–32

L. Stanford Sleepiness Scale III–37

M. Functional Outcomes of Sleep Questionnaire III–38

A. A.P.N.E.A. Net: The Apnea Patient's News, Education & Awareness Network—Sleep Apnea Questionnaire

Relevant Questions:

Circle the numbers of the comments that apply to you.

1. I have been told that I snore.
2. I sometimes suffer from daytime sleepiness.
3. I have dozed off in church on occasion.
4. If I doze off, I sometimes wake up with a "snort."
5. I have been told that I hold my breath or stop breathing in my sleep.
6. I have high blood pressure.
7. I toss and turn a lot in my sleep.
8. I get up to visit the bathroom more than once a night.
9. I often feel sleepy and struggle to stay alert, especially during afternoon meetings.
10. I sometimes fall asleep while watching TV.
11. I have fallen asleep at a stop light or stop sign.
12. I have actually fallen asleep while driving.
13. I wish I had more energy and less fatigue.
14. My neck measures over 17 inches (males) or over 16 inches (females)
15. I am more than 15 pounds overweight.
16. I seem to be losing my sex drive, or my ability to perform in bed.
17. I sometimes get heartburn in the middle of the night.
18. I frequently wake with a bad taste in my mouth, or a dry mouth and throat.
19. I often get morning headaches.
20. When I cannot wake up from a nightmare, I feel paralyzed and I panic.
21. I suddenly wake up gasping for breath.

22. I sometimes wake up with a pounding or irregular heartbeat.

23. I frequently feel depressed.

24. I feel as if I'm getting old too fast.

25. My friends and family say I'm sometimes grumpy and irritable.

26. I have short term memory problems.

27. I don't feel rested or refreshed, even after 8 or 10 hours of sleep.

28. I sometimes perspire a lot, especially at night.

29. I'm tired all the time.

30. I have great difficulty concentrating.

If you circled 5 or more symptoms, you could have OSA (obstructive sleep apnea). The risks of OSA include heart attacks, strokes, impotence, irregular heartbeat, high blood pressure and heart disease.

Take this form to your doctor. Treatments are available to eliminate apneas and snoring without surgery or drugs, but you must visit a sleep center or clinic to be tested.

Sleep tests are simple and painless, and are covered by most insurance policies. Sleep apnea is a life-threatening condition which kills over 38,000 people each year, according to the National Commission on Sleep Disorders Research (NCSDR).

This questionnaire is the result of collaboration between Kathleen Chittenden, Gwynne Wolin and Dave Hargett, all of whom are patients or lay persons interested in sleep disorders, especially sleep apnea. This questionnaire is intended to raise the awareness level of sleep apnea among the millions of persons who have undiagnosed sleep apnea and to provide a springboard for discussion between those persons and their primary care physicians. If in doubt, or if you need additional information, you may need to be referred to a sleep specialist. There is also a wealth of knowledge available on the Internet or in the newsgroup alt.support.sleep-disorder. You may also want to contact the American Sleep Apnea Association at 202-293-3650.

B. Epworth Sleepiness Scale

Relevant Questions:

EPWORTH SLEEPINESS SCALE

In contrast to just feeling tired, how likely are you to doze off or fall asleep in the following situations? (Even if you have not done some of these things recently, try to work out how they would have affected you.) Use the following scale to choose the most appropriate number for each situation.

0 = Would never doze
1 = Slight chance of dozing
2 = Moderate chance of dozing
3 = High chance of dozing

Situation	Chance of Dozing
Sitting & Reading	_____
Watching TV	_____
Sitting inactive in a public place (i.e. theatre)	_____
As a car passenger for an hour without a break	_____
Lying down to rest in the afternoon	_____
Sitting & talking to someone	_____
Sitting quietly after lunch without alcohol	_____
In a car, while stopping for a few minutes in traffic	_____

A score of greater than 10 is a definite cause for concern as it indicate significant excessive daytime sleepiness.

EPWORTH SLEEPINESS SCALE:

How likely are you to doze off or fall asleep in the following situations:

Scale: 0 = would never doze 1 = slight chance 2 = moderate chance 3 = high chance

SITUATIONS	SCALE
Sitting and talking to someone	0 1 2 3
Sitting inactive in a public place	0 1 2 3
Sitting quietly after lunch without alcohol	0 1 2 3
Sitting and reading	0 1 2 3
Watching television	0 1 2 3
Lying down to rest in the afternoon	0 1 2 3
In a car while stopped in traffic	0 1 2 3
As a passenger in a car	0 1 2 3

Patient Label

Severity of Daytime Sleepiness Scale

Mild: Unwanted sleepiness or involuntary sleep episodes occur during activities that require little attention. Examples include sleepiness that is likely to occur while watching television, reading, or traveling as a passenger. Symptoms produce only minor impairment of social or occupational function.

Moderate: Unwanted sleepiness or involuntary sleep episodes occur during activities that require some attention. Examples include uncontrollable sleepiness that is likely to occur while attending activities such as concerts, meetings, or presentations. Symptoms produce moderate impairment of social or occupational function.

Severe: Unwanted sleepiness or involuntary sleep episodes occur during activities that require more active attention. Examples include uncontrollable sleepiness while eating, during conversation, walking, or driving. Symptoms produce marked impairment in social or occupational function.

Is your level of sleepiness: None ____ Mild ____ Moderate ____ Severe ____ ?
Refer to Sleepiness Scale above.

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING BELOW
OR PROVIDE A LIST THAT CAN BE COPIED.
INCLUDE NON-PRESCRIPTION DRUGS AND VITAMINS.

Name of Medication	Dose - mg/day and time of day you take it	For how long have you taken this medication?	Reason you are taking this medication.

C. Exempla Healthcare Sleep Disorders Laboratory: Patient Education and Screening Questionnaire

Relevant Questions:

Exempla HEALTHCARE

SLEEP DISORDERS LABORATORY

Patient Name: _____

Age: _____ Sex: _____

Height: _____ Weight: _____Neck Size: _____

PATIENT EDUCATION AND SCREENING QUESTIONNAIRE

PLEASE COMPLETE QUESTIONNAIRE & fax to the SLEEP LAB at 303-403-3665 or bring with you to your pre-study interview.

Do you have any questions about the test? _____

Do you have any special requests or services required during your sleep test? _____

_____

If we need to contact you in the future, can we leave a phone message at home? Yes ____ No ____

Do you go to bed at a regular time every night? Yes ____ No ____ What time? _____

Do you wake up at a regular time every day? Yes ____ No ____ What time? _____

On the average, how many hours do you spend in your bed each night? _____

On the average, how many hours do you sleep each night? _____

How long does it normally take for you to fall asleep after Bedtime? _____

While in bed, do you read? Yes ____ No ____ and/or watch TV? Yes ____ No ____

Do you take naps? Yes ____ No ____ If so, what times? _____ for how long? _____

Do you smoke? Yes ___ No ___How much?_____ How long? _____

Do you drink alcohol? Yes __ No __ What/ how much/ how often/ time of day? _____

Do you use caffeine? Yes __ No __ What/ how much/ how often/ time of day? _____

Has anyone observed you snoring? Yes ____ No ____ Not Sure ____

If yes, do you snore every night? Yes ____ No ____ Not Sure ____

On a scale of 1-10, 10 being the loudest, how loud do you snore? _____

Has anyone observed you having pauses in your breathing at night? Yes ____ No ____

How long do these pauses last? _____How long has this occurred? _____

Do you have daytime sleepiness? Yes ____ No ____ and/or fatigue? Yes ____ No ____

Do you have leg jerks at night? Yes ____ No ____

Do you have morning headaches? Yes ____ No ____

Do you have shortness of breath at night? Yes ____ No ____

Do you have night sweats? Yes ____ No ____

Do you wake with a sore throat Y/N Dry mouth Y/N Nasal congestion Y/N

Has your bed partner been forced into another room because of your snoring? Yes ___ No ___

Have you experienced impotence or decreased libido? Yes ____ No ____

Do you have difficulty driving due to your sleepiness? Yes ____ No ____

Have you ever fallen asleep while driving? Yes ___ No ___ How many times? _____

Is your weight stable? Yes ____ No ____

Have you gained weight __ or lost weight __? # of pounds _____ Over what course of time?_____

Do you wet the bed (enuresis)? Yes ___ No ___

Do you have difficulty falling or staying asleep? Please specify._____

_____

Does chronic pain interfere with your sleep? Yes ____ No ____ On a scale of **1-10**, 10 being most severe, rate your pain: _____ **Why** do you have pain? _____

_____

Do you have difficulty sleeping away from home? Yes ____ No ____

Do you have hallucinations while falling asleep or upon awakening? Yes ____ No ____

Do you ever have sudden unexplained, involuntary or inappropriate sleep attacks? Yes ____ No ____

Do you dream during these attacks? Yes ____ No ____

Do you have total body paralysis while falling asleep or upon awakening? Yes ____ No ____

Do you have severe muscular weakness elicited by strong emotions (cataplexy)? Yes ____ No ____

Has your nose ever been broken? Yes ____ No ____ How and when? _____

Do you have a deviated septum? Yes ____ No ____

Have your Tonsils been removed? Yes ___ No ___ Have your Adenoids been removed? Yes ___ No ___

Have you had surgery to remove the uvula (UPPP)? Yes ____ No ____

Have you had any other nasal or throat surgery? Yes ____ No ____ Explain _____

Do you have Gastroesophageal Reflux Disorder (GERD) Y/N Hypertension (high blood pressure) Y/N

Chronic Obstructive Pulmonary Disease Y/N Asthma Y/N Diabetes Y/N Depression Y/N

Do you have any additional comments or observations? _____

_____

Do you have any drug allergies? _____

Patient Name _____

D. Infant Screening Questionnaire

Objective: To develop and validate (using subjective and objective methods) a Brief Infant Screening Questionnaire (BISQ) appropriate for screening in pediatric settings.

Methodology: Two studies were performed to assess the properties of the BISQ. Study I compared BISQ measures with sleep diary measures and objective actigraphic sleep measures for clinical (***n*** = 43) and control (***n*** = 57) groups of infants (5–29 months of age). The second study was based on an Internet survey of 1,028 respondents who completed the BISQ posted on an infant sleep Web site. The questionnaire appears below.

Relevant Questions:

Brief Infant Screening Questionnaire

Please mark only one (most appropriate) choice, when you respond to items with a few options.

Name of Responder: _____ Date: _____
Role of Responder: ☐ Father ☐ Mother ☐ Grandparent ☐ Other, Specify: _____
Name of the child: _____ Date of Birth: Month _____ Day: _____ Year: _____
Sex: ☐ Male ☐ Female Birth order of the child: ☐ Oldest ☐ Middle ☐ Youngest
Sleeping arrangement:
☐ Infant crib in a separate room ☐ Infant crib in parents' room
☐ In parents' bed ☐ Infant crib in room with sibling
☐ Other, Specify: _____

In what position does your child sleep most of the time?
☐ On his/her belly ☐ On his/her side ☐ On his/her back
How much time does your child spend in sleep during the NIGHT (between 7 in the evening and 7 in the morning)? Hours: _____ Minutes: _____
How much time does your child spend in sleep during the DAY (between 7 in the morning and 7 in the evening)? Hours: _____ Minutes: _____

Average number of night wakings per night: _____
How much time during the night does your child spend in wakefulness (from 10 in the evening to 6 in the morning)? Hours: _____ Minutes: _____
How long does it take to put your baby to sleep in the evening?
Hours: _____ Minutes: _____
How does your baby fall asleep?
☐ While feeding ☐ Being rocked ☐ Being held
☐ In bed alone ☐ In bed near parent
When does your baby usually fall asleep for the night:
Hours: _____ Minutes: _____
Do you consider your child's sleep as a problem?
☐ A very serious problem ☐ A small problem ☐ Not a problem at all

E. Leeds Sleep Evaluation Questionnaire

Objective: The Leeds Sleep Evaluation Questionnaire (LSEQ) comprises 10 self-rating 100 mm line analog questions concerned with sleep and early morning behavior. A literature search identified 83 studies in peer-reviewed journals that reported the use of the LSEQ for psychopharmacological investigations of drug effects on self-reported aspects of sleep. High internal consistency and reliability of the questionnaire have been demonstrated. Findings from studies involving a variety of psychoactive agents indicated that the LSEQ was able to quantify subjective impressions of sleep and waking and the effects of drugs in healthy volunteers and patients with depression and insomnia. In accordance with their known activity profile, nocturnal administration of sedative hypnotic agents and antihistamines induced dose-related improvements in self-reported ease of getting to sleep and in quality of sleep but a decrease in alertness and behavioral integrity the following morning. Psychostimulants, on the other hand, impaired subjective ratings of sleep and increased early morning alertness. Antidepressants and certain anxiolytic agents improved both self-reported sleep aspects and early morning alertness. Treatment effects measured by the LSEQ corresponded to those measured for the same drugs by other assessment methods. These data indicate that the LSEQ is a robust and reliable instrument for psychopharmacological evaluations. Self-evaluations of sleep, as obtained by the LSEQ, can

therefore provide consistent and meaningful measures for estimating the effectiveness of sleep modulators and sedative-hypnotic drugs.

Methodology: A computer-assisted MEDLINE and Web-of-Science (WOS) search was conducted to identify studies that report the effects of drugs on psychomotor performance from placebo- and verum-controlled studies reported in papers published between the original publication of the LSEQ (Parrott & Hindmarch, 1978) and March 2001. The search of these databases ensured that only studies published in peer-reviewed journals meeting specific criteria for acceptance were included in the review. Search terms included *Leeds*, *Sleep*, *Evaluation*, *Questionnaire*, *Visual Analog*, and specific drug names. The search was limited to adequately controlled studies using placebo or verum control groups. Data have been also included from studies cited in these publications as well as publications provided by Professor I. Hindmarch (Guildford, UK) so long as the studies satisfied the inclusion criteria and the data were presented in a format that enabled the comparison with other findings to be performed. The review concentrates only on psychometric assessments of sleep and takes no account of efficacy variables of the drugs investigated (such as antidepressant effects of serotonin-reuptake inhibitors, etc.). The questionnaire appears below.

Relevant Questions:

The Leeds Sleep Evaluation Questionnaire

1. How would you compare getting to sleep using the medication with getting to sleep normally (i.e. without medication)?

   ☐ Harder than usual/easier than usual

   ☐ Slower than usual/quicker than usual

   ☐ Felt less drowsy than usual/felt more drowsy than usual.

2. How would you compare the quality of sleep using the medication with nonmedicated (your usual) sleep?

   ☐ More restless than usual/more restful than usual

   ☐ More periods of wakefulness than usual/fewer periods of wakefulness than usual.

3. How did your awakening after medication compare with your usual pattern of awakening?

   ☐ More difficult than usual/easier than usual

   ☐ Took longer than usual/took shorter than usual

4. How did you feel on wakening?

   ☐ Tired/alert

5. How do you feel now?

   ☐ Tired/alert.

6. How was your sense of balance and coordination upon getting up?

   ☐ More clumsy than usual/less clumsy than usual

Note. A 10 cm line separates the two halves of each question. The questionnaire instructions are: 'Each question is answered by placing a vertical mark on the answer line. If no change was experienced then place your mark in the middle of the line. If a change was experienced then the position of your mark will indicate the nature and extent of the change, i.e. large charges near the ends of the line, small changes near the middle.'

F. Maternal Child Supervision Questionnaire, 1961

Objective: To determine the role that mothers play in child supervision by employing a mail survey.

Methodology: A survey (see below) was sent out to 2,000 mothers with a list of potential maternal concerns. Participants were asked to fill out the questionnaire along with demographic characteristics.

Relevant Questions:

CHILD DEVELOPMENT

APPENDIX

DUPLICATE OF STUDY QUESTIONNAIRE

Baby's date of birth _____ Today's date _____

Baby's weight at birth _____ Mother's age _____

Baby is a boy ☐ girl ☐ How many *other* children do you have? ____

The following list is based on doctors' reports of the many questions or worries that mothers sometimes have about their new babies. Which of these, if any, have *worried* you about your baby?

	No Worry (check)	Some Worry (check)	Considerable Worry (check)	Please Describe
Stomach (too large, small, hard, soft, swollen, etc.)	☐	☐	☐	_____ _____
Breathing (uneven, hiccoughs, gags, chokes, gasps, grunts, etc.)	☐	☐	☐	_____ _____
Hair (too much, too little, falling out, etc.)	☐	☐	☐	_____ _____
Eyes (puffy, red, crossed, color, etc.)	☐	☐	☐	_____ _____
Ears (shape, size, color, etc.)	☐	☐	☐	_____ _____
Nose (size, shape, running, etc.)	☐	☐	☐	_____ _____
Mouth-Lips (size, shape, color, sore, swallowing, thumb-sucking, etc.)	☐	☐	☐	_____ _____
Sleeping (too much, not enough, not regular, restless, etc.)	☐	☐	☐	_____ _____
Accidents (while sleeping, eating, playing, bathing, etc.)	☐	☐	☐	_____ _____
Head (size, shape, soft spot, etc.)	☐	☐	☐	_____ _____
Weight (not gaining, too fat, too thin, etc.)	☐	☐	☐	_____ _____
Crying (too much, too little, strong, weak, turns color, etc.)	☐	☐	☐	_____ _____

DUPLICATE OF STUDY QUESTIONNAIRE (continued from previous page)

NAVEL (swollen, too large, small, bleeding, odor, etc.)	☐	☐	☐	_____ _____
BUTTOCKS (diaper rash, sore, color, etc.)	☐	☐	☐	_____ _____
SKIN (oily, dry, rash, scratches, etc.)	☐	☐	☐	_____ _____
BOWEL MOVEMENTS (odor, color, too often, too loose, hard, etc.)	☐	☐	☐	_____ _____
URINE (odor, color, too often, too little, etc.)	☐	☐	☐	_____ _____
EATING (not enough, too much, not regular, hungry, disagrees, etc.)	☐	☐	☐	_____ _____
DIGESTION (spitting, burping, gas, vomiting, colic, etc.)	☐	☐	☐	_____ _____
LEGS-FEET (too thin, too heavy, not straight, etc.)	☐	☐	☐	_____ _____
ARMS-HANDS (too thin, too heavy, not straight, etc.)	☐	☐	☐	_____ _____
OTHER (spoiling baby, food preparation, bathing, clothing, diapering, etc.)	☐	☐	☐	_____ _____

Have you chosen a doctor to care for your baby yet? Yes ☐ No ☐

If yes, has the doctor examined your baby in—
(Please check) a. the hospital ☐ b. the office ☐
c. your home ☐ d. baby not examined by doctor yet ☐

Did the doctor mention anything about your baby that would need special care or attention? (Please explain) _____

About yourself, how many years were you in— Grade School ____ yrs.;
High School ____ yrs.; College ____ yrs.; Postgraduate ____ yrs.

Comments _____

G. Parental Interactive Bedtime Behavior Scale

Objective: The development of a new parental self-report questionnaire, the Parental Interactive Bedtime Behavior Scale (PIBBS), is described. The PIBBS was designed to capture a wide range of parental behaviors used to settle infants to sleep. The commonest behaviors employed were feeding, talking softly to the child, cuddling in the arms, and stroking. A factor analysis revealed five settling strategies: "active physical comforting" (e.g., cuddling in arms); "encouraging infant autonomy" (e.g., leaving to cry); "movement" (e.g., car rides), "passive physical comforting" (e.g., standing next to the crib without picking the infant up), and "social comforting" (e.g., reading a story). Use of excessive "active physical comforting" and reduced "encourage autonomy" strategy was associated with infant sleeping problems. Regarding developmental change in strategy between 1 and 2 years, the later the onset at which "encourage autonomy" became the principal strategy used, the more likely that persistent infant sleeping problems would be present. Factors accounting for the change in strategy use over time were: 1) parental adaptation to infant developmental maturation; 2) the interaction between maternal cognition and strategy, and, to a lesser extent 3) the interaction between infant temperament and parental strategy.

Methodology: The items composing the PIBBS were designed to reflect a wide range of behaviors that parents may use in trying to settle children to sleep. The sources for the items chosen were: 1) parental descriptions of settling behaviors derived from clinical work with parents and infants with sleeping problems, 2) discussions with professional colleagues, and 3) the researcher's personal experience as a parent. The items chosen were hypothesized to fall into a number of different domains representing one or more general strategies that parents might employ to settle children. The first domain was "physical methods," which included the use of swaddling, stroking, cuddling, carrying around the house, walks in a carriage, and car rides to settle the child. The second domain was "social methods," which included the use of music, talking softly, singing a lullaby, reading a story, and playing to settle the child. The third domain was "oral comforting methods," which included offering a special toy or cloth (which children often suck), a dummy (pacifier), or feeding. The fourth domain was "distance/proximity methods," which included leaving to cry, standing near the crib without picking baby up, settling on the sofa, lying next to child and settling in the parental bed. A fifth domain was "medication methods," which included the use of Calpol (a commonly used paracetamol preparation), gripe water, Alcohol, and sleeping medication to settle children to sleep. Hence the questionnaire was designed to tap a number of different constructs that are nevertheless likely to be correlated. This is because parents are likely to use one set of strategies predominantly but may use others either concurrently or at different times. The sample size was 467 mothers. The questionnaire can be found below.

Relevant Questions:

The Parental Interactive Bedtime Behaviour Scale (PIBBS)

Which methods do you use to help settle your baby off to sleep? How often do you use each one?
(Please tick the appropriate boxes; one tick per row)

		Never 0	Rarely 1	Some-times 2	Often 3	Very often 4
1	Stroke part of child or pat	[ ]	[ ]	[ ]	[ ]	[ ]
2	Cuddling or rocking in arms	[ ]	[ ]	[ ]	[ ]	[ ]
3	Carrying around house in arms	[ ]	[ ]	[ ]	[ ]	[ ]
4	Walks in pram or buggy	[ ]	[ ]	[ ]	[ ]	[ ]
5	Car rides	[ ]	[ ]	[ ]	[ ]	[ ]
6	Music tape or musical toy	[ ]	[ ]	[ ]	[ ]	[ ]
7	Talking softly to child	[ ]	[ ]	[ ]	[ ]	[ ]
8	Singing a lullaby	[ ]	[ ]	[ ]	[ ]	[ ]
9	Reading a story to child	[ ]	[ ]	[ ]	[ ]	[ ]
10	Playing with child	[ ]	[ ]	[ ]	[ ]	[ ]
11	Offer a special toy/cloth	[ ]	[ ]	[ ]	[ ]	[ ]
12	Give a feed/drink	[ ]	[ ]	[ ]	[ ]	[ ]
13	Leave to cry	[ ]	[ ]	[ ]	[ ]	[ ]
14	Stand near cot without picking baby up	[ ]	[ ]	[ ]	[ ]	[ ]
15	Settle on sofa with parent	[ ]	[ ]	[ ]	[ ]	[ ]
16	Lie with child next to their cot	[ ]	[ ]	[ ]	[ ]	[ ]
17	Settle in parent's bed	[ ]	[ ]	[ ]	[ ]	[ ]
18	Give sleeping medication	[ ]	[ ]	[ ]	[ ]	[ ]
19	Alcohol	[ ]	[ ]	[ ]	[ ]	[ ]

Office Use only

Strategies	*Sub-scale score*	*% Score*
Active physical comforting (items, 1+2+3+12+15+17)	□/24 × 100 =	□*a*
Encourage autonomy (items 6+11+13)	□/12 × 100 =	□*b*
Settle by movement (items 4 + 5)	□/8 × 100 =	□*c*
Passive physical comforting (items 14+16)	□/8 × 100 =	□*d*
Social comforting (items 7+8+9+10)	□/16 × 100 =	□*e*

Total % score = $(a-b+c+d+e+100)/5 =$ □

H. Pediatric Sleep Questionnaire

Developed by:
Ronald D. Chervin, M.D.
Professor of Neurology and Director of the Sleep Disorders Center
University of Michigan, Ann Arbor

Relevant Questions:

Child's Name: _____ _____ _____
(Last) (First) (M.I.)

Name of Person Answering Questions: _____

Relation to Child: _____

Your phone number (please include area code):

days: _____ **evenings:** _____

Relative's name and number in case we cannot reach you:

_____

Instructions:
Please answer the questions on the following pages regarding the behavior of your child during sleep and wakefulness. The questions apply to how your child acts in general, not necessarily during the past few days since these may not have been typical if your child has not been well. If you are not sure how to answer any question, please feel free to ask your husband or wife, child, or physician for help. You should circle the correct response or *print* your answers neatly in the space provided. A "Y" means "yes," "N" means "no," and "DK" means "don't know." When you see the word "usually" it means "more than half the time" or "on more than half the nights."

GENERAL INFORMATION ABOUT YOUR CHILD:

	Office use only
Today's Date: . Month Day Year	GI2
Where are you completing this questionnaire? _____.	GI3
Date of Child's Birth: . Month Day Year	GI4
Sex: Male or Female? _____.	GI5
Current Height (feet/inches) : .	GI6
Current Weight (pounds) : .	GI7
Grade in school (if applicable):_____.	GI8
Racial/Ethnic Background of your Child (please circle): 1.) American Indian 2.) Asian-American 3.) African-American 4.) Hispanic 5.) White/not Hispanic 6.) Other or unknown	GI9

A. Nighttime and sleep behavior: WHILE SLEEPING, DOES YOUR CHILD ...	
... ever snore?	Y N DK
... snore more than half the time?	Y N DK
... always snore?	Y N DK
... snore loudly?	Y N DK
... have "heavy" or loud breathing?	Y N DK
... have trouble breathing, or struggle to breathe? HAVE YOU EVER ...	Y N DK
... seen your child stop breathing during the night? If so, please describe what has happened:	Y N DK
... been concerned about your child's breathing during sleep?	Y N DK
... had to shake your sleeping child to get him or her to breathe, or wake up and breathe?	Y N DK
... seen your child wake up with a snorting sound? DOES YOUR CHILD ...	Y N DK
... have restless sleep?	Y N DK
... describe restlessness of the legs when in bed? ... have "growing pains" (unexplained leg pains)? ... have "growing pains" that are worst in bed? WHILE YOUR CHILD SLEEPS, HAVE YOU SEEN ...	Y N DK Y N DK Y N
... brief kicks of one leg or both legs? ... repeated kicks or jerks of the legs at regular intervals (i.e., about every 20 to 40 seconds)? AT NIGHT, DOES YOUR CHILD USUALLY ...	Y N DK Y N DK
... become sweaty, or do the pajamas usually become wet with perspiration?	Y N DK
... get out of bed (for any reason)?	Y N DK
... get out of bed to urinate? If so, how many times each night, on average?	Y N DK
Does your child usually sleep with the mouth open?	Y N DK
Is your child's nose usually congested or "stuffed" at night?	Y N DK
Do any allergies affect your child's ability to breathe through the nose? DOES YOUR CHILD ...	Y N DK
... tend to breathe through the mouth during the day?	Y N DK

... have a dry mouth on waking up in the morning?	Y N DK
... complain of an upset stomach at night?	Y N DK
... get a burning feeling in the throat at night?	Y N DK
... grind his or her teeth at night?	Y N DK
... occasionally wet the bed?	Y N DK
Has your child ever walked during sleep ("sleep walking")?	Y N DK
Have you ever heard your child talk during sleep ("sleep talking")?	Y N DK
Does your child have nightmares once a week or more on average?	Y N DK
Has your child ever woken up screaming during the night?	Y N DK
Has your child ever been moving or behaving, at night, in a way that made you think your child was neither completely awake nor asleep? If so, please describe what has happened:	Y N DK
Does your child have difficulty falling asleep at night?	Y N DK
How long does it take your child to fall asleep at night? (a guess is O.K.)	_____
At bedtime does your child usually have difficult "routines" or "rituals," argue a lot, or otherwise behave badly?	Y N DK
DOES YOUR CHILD ... ... bang his or her head or rock his or her body when going to sleep?	Y N DK
... wake up more than twice a night on average?	Y N DK
... have trouble falling back asleep if he or she wakes up at night?	Y N DK
... wake up early in the morning and have difficulty going back to sleep?	Y N DK
Does the time at which your child goes to bed change a lot from day to day?	Y N DK
Does the time at which your child gets up from bed change a lot from day to day? WHAT TIME DOES YOUR CHILD USUALLY ...	Y N DK
... go to bed during the week?	
... go to bed on the weekend or vacation?	
... get out of bed on weekday mornings?	
... get out of bed on weekend or vacation mornings?	

B. Daytime behavior and other possible problems: DOES YOUR CHILD ...	Office Use Only
... wake up feeling unrefreshed in the morning?	Y N DK
... have a problem with sleepiness during the day?	Y N DK
... complain that he or she feels sleepy during the day?	Y N DK
Has a teacher or other supervisor commented that your child appears sleepy during the day?	Y N DK
Does your child usually take a nap during the day?	Y N DK
Is it hard to wake your child up in the morning?	Y N DK
Does your child wake up with headaches in the morning?	Y N DK
Does your child get a headache at least once a month, on average?	Y N DK
Did your child stop growing at a normal rate at any time since birth? If so, please describe what happened:	Y N DK
Does your child still have tonsils? If not, when and why were they removed?: HAS YOUR CHILD EVER ...	Y N DK
... had a condition causing difficulty with breathing? If so, please describe:	Y N DK
... had surgery? If so, did any difficulties with breathing occur before, during, or after surgery?	Y N DK Y N DK
... become suddenly weak in the legs, or anywhere else, after laughing or being surprised by something?	Y N DK
... felt unable to move for a short period, in bed, though awake and able to look around?	Y N DK
Has your child felt an irresistible urge to take a nap at times, forcing him or her to stop what he or she is doing in order to sleep?	Y N DK
Has your child ever sensed that he or she was dreaming (seeing images or hearing sounds) while still awake?	Y N DK
Does your child drink caffeinated beverages on a typical day (cola, tea, coffee)? If so, how many cups or cans per day?	Y N DK
Does your child use any recreational drugs? If so, which ones and how often?:	Y N DK
Does your child use cigarettes, smokeless tobacco, snuff, or other tobacco products? If so, which ones and how often?:	Y N DK

Is your child overweight? If so, at what age did this first develop?	Y N DK _____ years
Has a doctor ever told you that your child has a high-arched palate (roof of the mouth)?	Y N DK
Has your child ever taken Ritalin (methylphenidate) for behavioral problems?	Y N DK
Has a health professional ever said that your child has attention-deficit disorder (ADD) or attention-deficit/hyperactivity disorder (ADHD)?	Y N DK

C. Other Information

1. If you are currently at a clinic with your child to see a physician, what is the problem that brought you?

2. If your child has long-term medical problems, please list the three you think are most significant.

_____.

_____ _____.

_____ _____.

3. Please list any medications your child currently takes:

Medicine	Size (mg) or amount per dose	Taken when?
_____	_____	_____
Effect: _____.		
_____	_____	_____
Effect: _____.		
_____	_____	_____
Effect: _____.		
_____	_____	_____
Effect: _____.		

4. Please list any medication your child has taken in the past if the purpose of the medication was to improve his or her behavior, attention, or sleep:

Medicine	Size (mg) or amount per dose	Taken how often?	Dates Taken
_____	_____	_____	_____
Effect: _____.			
_____	_____	_____	_____
Effect: _____.			
_____	_____	_____	_____
Effect: _____.			
_____	_____	_____	_____
Effect: _____.			

5. Please list any sleep disorders diagnosed or suspected by a physician in your child. For each problem, please list the date it started and whether or not it is still present.

6. Please list any psychological, psychiatric, emotional, or behavioral problems diagnosed or suspected by a physician in your child. For each problem, please list the date it started and whether or not it is still present.

7. Please list any sleep or behavior disorders diagnosed or suspected in *your child's* brothers, sisters, or parents:

Relative	Condition
_____	_____
_____	_____
_____	_____

D. Additional Comments:

Please use the space below to print any additional comments you feel are important. Please also use this space to describe details regarding any of the above questions.

Instructions: Please indicate, by checking the appropriate box, how much each statement applies to this child:

This child often...	Does not apply 0	Applies just a little 1
... does not seem to listen when spoken to directly.		
... has difficulty organizing tasks and activities.		
... is easily distracted by extraneous stimuli.		
... fidgets with hands or feet or squirms in seat.		
... is "on the go" or often acts as if "driven by a motor".		
... interrupts or intrudes on others (e.g., butts into conversations or games.		

THANK YOU

I. Sinai Hospital Sleep Disorder Assessment Questionnaire

Relevant Questions:

Sleep questionnaire #1

Sleep medicine specialists use the Epworth Sleepiness Scale to identify the level of day-time sleepiness. Using the following scale…

0 = never doze
1 = slight chance of dozing
2 = moderate chance of dozing
3 = high chance of dozing

...how would you rate these activities?

	SCORE
• Sitting and reading	
• Watching TV	
• Sitting, inactive in public	
• Car passenger (for an hour)	
• Lying down in the afternoon	
• Sitting and talking to someone	
• Sitting quietly after lunch (no alcohol)	
• Stopped for a few minutes in traffic	
	total

A total score of 10 or more suggests wake time sleepiness that may require a sleep evaluation to determine whether you are obtaining adequate sleep or may have an underlying sleep disorder. If your score is 10 or more, please share this information with your physician.

Sleep Questionnaire #2

SCORE

Determine your "Apnea Risk Score." Compare your total score from all five sections with the ranges below.

1. Do you have a history of snoring?
   a. no (0)
   b. mild infrequent (2)
   c. moderate/inconsistent (3)
   d. severe/ consistent (5)
2. Have you ever been told that you have "pauses" in breathing during sleep?
   a. no (0)
   b. yes, but infrequent (6)
   c. yes, inconsistent but most nights (8)
   d. yes, severely so (10)
3. Are you overweight?
   a. no (0)
   b. yes, <20 lb (1)
   c. yes, 20-50 lb (2)
   d. yes, > 50 lb (4)
4. Evaluate your sleepiness from Sleep Questionnaire #1 (the Epworth Sleepiness Scale)
   a. score less than or equal to 8 (0)
   b. 9-13 (3)
   c. 14-18 (5)
   d. greater than or equal to 19 (8)
5. Does your medical history include...
   a. high blood pressure (5)
   b. stroke (3)
   c. heart disease (3)
   d. morning headaches (2)
   e. more than three awakenings/night (2)
   f. excessive fatigue (2)
   g. depression (1)
   h. concentration problems (1)

Total Apnea Risk Score

5-9	Discuss complaints with your doctor.
10-14	Important to discuss with your doctor (consider sleep evaluation).
15-19	Sleep consultation or sleep study suggested.
20+	Significant risk of sleep apnea. Sleep study should be scheduled.

total

J. Sleep Apnea—The Phantom of the Night Questionnaire

Relevant Questions:

Quiz to identify sleep apnea syndrome

Answering the questions below will help you to understand whether sleep apnea is disturbing your sleep and disrupting your life.

The questions in the very important questions list are especially important; a "yes" answer strongly suggests that sleep apnea is the problem. To answer some questions, you will need the help of your roommate, bedmate, or a family member, or you may use a tape recorder or video recorder to identify snoring and pauses in breathing.

Very important questions (short quiz)

- Do you snore loudly each night?
- Do you have frequent pauses in breathing while you sleep (you stop breathing for ten seconds or longer)?
- Do you have headaches in the morning?
- Are you very tired or sleepy during the day?
- Do you fall asleep easily during the day?

During sleep and in the bedroom

- Do you snore loudly each night?
- Do you have frequent pauses in breathing while you sleep (you stop breathing for ten seconds or longer)?
- Do you experience heartburn during sleep at least twice a week?
- Are you restless during sleep, tossing and turning from one side to another?
- Do you wake feeling that you are choking or suffocating?
- Do you have some repetitive movement such as a jerk, or leg movements?
- Does your posture during sleep seem unusual—do you sleep sitting up or propped up by pillows?
- Do you have insomnia—waking up frequently and without an apparent reason?
- Do you have to get up to urinate several times during the night?

- Have you wet your bed?
- Have you fallen from bed?

While awake

- Do you wake up in the morning tired and foggy, not ready to face the day?
- Do you have headaches in the morning?
- Are you very tired or sleepy during the day?
- Do you fall asleep easily during the day?
- Do you nod off readily or fight to stay awake while driving?
- Do you have difficulty concentrating, being productive, and completing tasks at work?
- Do you carry out routine tasks in a daze?
- Have you ever arrived home in your car but couldn't remember the trip from work?

Adjustment and emotional issues

- Are you having serious relationship problems at home, with friends and relatives, or at work?
- Are you afraid that you may be out of touch with the real world, unable to think clearly, losing your memory, or emotionally ill?
- Do your friends tell you that you're not acting like yourself?
- Do you feel like you are depressed? Do you feel overwhelmed by your life? Do you lack interest in your activities?
- Are you irritable and angry, especially first thing in the morning?

Medical, physical condition, and lifestyle

- Are you overweight?
- Do you have high blood pressure? Is it hard to control?
- Do you have heart disease? Do you have difficulty controlling the symptoms with medication?
- Do you have pains in your bones and joints?
- Do you have trouble breathing through your nose?

- Do you often have a drink of alcohol before going to bed?
- Do you have a small chin and receding jaw?
- If you are a man, is your collar size 17 inches (42 centimeters) or larger?
- Have you been diagnosed with severe esophageal reflux?
- Do you have family members or relatives who have sleep apnea?

What your answers may mean

A "yes" answer to any of these questions may be a clue that an underlying sleep disorder exists. This may be sleep apnea, another sleep disorder, or even a problem not related to sleep. Each of the questions points to a symptom. Symptoms are the clues, sometimes subtle and perceived only by the patient (such as memory loss), and sometimes overt and observable by friend or family (such as snoring), which indicate that the mind or body is diseased. Your doctor, trained to see symptoms as the manifestation of disease, can help you interpret and understand the basis of your condition.

K. Pittsburgh Sleep Quality Index

Appendix. Pittsburgh Sleep Quality Index (PSQI)

Name _____ ID # _____ Date _____ Age _____

Instructions:

The following questions relate to your usual sleep habits during the past month *only*. Your answers should indicate the most accurate reply for the *majority* of days and nights in the past month. Please answer all questions.

1. During the past month, when have you usually gone to bed at night?

   USUAL BED TIME _____

2. During the past month, how long (in minutes) has it usually take you to fall asleep each night?

   NUMBER OF MINUTES _____

3. During the past month, when have you usually gotten up in the morning?

   USUAL GETTING UP TIME _____

4. During the past month, how many hours of *actual sleep* did you get at night? (This may be different than the number of hours you spend in bed.)

   HOURS OF SLEEP PER NIGHT _____

For each of the remaining questions, check the one best response. Please answer *all* questions.

5. During the past month, how often have you had trouble sleeping because you...

   (a) Cannot get to sleep within 30 minutes

Not during the past month _____	Less than once a week _____	Once or twice a week _____	Three or more times a week _____

   (b) Wake up in the middle of the night or early morning

Not during the past month _____	Less than once a week _____	Once or twice a week _____	Three or more times a week _____

   (c) Have to get up to use the bathroom

Not during the past month _____	Less than once a week _____	Once or twice a week _____	Three or more times a week _____

   (d) Cannot breathe comfortably

Not during the past month _____	Less than once a week _____	Once or twice a week _____	Three or more times a week _____

   (e) Cough or snore loudly

Not during the past month _____	Less than once a week _____	Once or twice a week _____	Three or more times a week _____

   (f) Feel too cold

Not during the past month _____	Less than once a week _____	Once or twice a week _____	Three or more times a week _____

   (g) Feel too hot

Not during the past month _____	Less than once a week _____	Once or twice a week _____	Three or more times a week _____

   (h) Had bad dreams

Not during the past month _____	Less than once a week _____	Once or twice a week _____	Three or more times a week _____

   (i) Have pain

Not during the past month _____	Less than once a week _____	Once or twice a week _____	Three or more times a week _____

(j) Other reason(s), please describe _____

_____

How often during the past month have you had trouble sleeping because of this?

Not during the past month _____	Less than once a week _____	Once or twice a week _____	Three or more times a week _____

6. During the past month, how would you rate your sleep quality overall?
   - Very good _____
   - Fairly good _____
   - Fairly bad _____
   - Very bad _____
7. During the past month, how often have you taken medicine (prescribed or "over the counter") to help you sleep?

Not during the past month _____	Less than once a week _____	Once or twice a week _____	Three or more times a week _____

8. During the past month, how often have you had trouble staying awake while driving, eating meals, or engaging in social activity?

Not during the past month _____	Less than once a week _____	Once or twice a week _____	Three or more times a week _____

9. During the past month, how much of a problem has it been for you to keep up enough enthusiasm to get things done?
   - No problem at all _____
   - Only a very slight problem _____
   - Somewhat of a problem _____
   - A very big problem _____
10. Do you have a bed partner or roommate?
    - No bed partner or roommate _____
    - Partner/roommate in other room _____
    - Partner in same room, but not same bed _____
    - Partner in same bed _____

If you have a roommate or bed partner, ask him/her how often in the past month you have had...

(a) Loud snoring

Not during the past month _____	Less than once a week _____	Once or twice a week _____	Three or more times a week _____

(b) Long pauses between breaths while asleep

Not during the past month _____	Less than once a week _____	Once or twice a week _____	Three or more times a week _____

(c) Legs twitching or jerking while you sleep

Not during the past month _____	Less than once a week _____	Once or twice a week _____	Three or more times a week _____

(d) Episodes of disorientation or confusion during sleep

Not during the past month _____	Less than once a week _____	Once or twice a week _____	Three or more times a week _____

(e) Other restlessness while you sleep; please describe _____

_____

Not during the past month _____	Less than once a week _____	Once or twice a week _____	Three or more times a week _____

Scoring Instructions for the Pittsburgh Sleep Quality Index

The Pittsburgh Sleep Quality Index (PSQI) contains 19 self-rated questions and 5 questions rated by the bed partner or roommate (if one is available). Only self-rated questions are included in the scoring. The 19 self-rated items are combined to form seven "component" scores, each of which has a range of 0-3 points. In all cases, a score of "0" indicates no difficulty, while a score of "3" indicates severe difficulty. The seven component scores are then added to yield one "global" score, with a range of 0-21 points, "0" indicating no difficulty and "21" indicating severe difficulties in all areas.

Scoring proceeds as follows:

Component 1: Subjective sleep quality

Examine question #6, and assign scores as follows:

Response	Component 1 score
"Very good"	0
"Fairly good"	1
"Fairly bad"	2
"Very bad"	3

Component 1 score: _____

Component 2: Sleep latency

1. Examine question #2, and assign scores as follows:

Response	Score
≤ 15 minutes	0
16-30 minutes	1
31-60 minutes	2
> 60 minutes	3

Question #2 score: _____

2. Examine question #5a, and assign scores as follows:

Response	Score
Not during the past month	0
Less than once a week	1
Once or twice a week	2
Three or more times a week	3

Question #5a score: _____

3. Add #2 score and #5a score

Sum of #2 and #5a: _____

4. Assign component 2 score as follows:

Sum of #2 and #5a	Component 2 score
0	0
1-2	1
3-4	2
5-6	3

Component 2 score: _____

Component 3: Sleep duration

Examine question #4, and assign scores as follows:

Response	Component 3 score
> 7 hours	0
6-7 hours	1
5-6 hours	2
< 5 hours	3

Component 3 score: _____

Component 4: Habitual sleep efficiency

(1) Write the number of hours slept (question # 4) here: _____

(2) Calculate the number of hours spent in bed:

Getting up time (question # 3): _____

− Bedtime (question # 1): _____

Number of hours spent in bed: _____

(3) Calculate habitual sleep efficiency as follows:

(Number of hours slept/Number of hours spent in bed) × 100 = Habitual sleep efficiency (%)

(_____/_____) × 100 = _____%

(4) Assign component 4 score as follows:

Habitual sleep efficiency %	Component 4 score
> 85%	0
75-84%	1
65-74%	2
< 65%	3

Component 4 score: _____

Component 5: Sleep disturbances

(1) Examine questions # 5b-5j, and assign scores for *each* question as follows:

Response	Score
Not during the past month	0
Less than once a week	1
Once or twice a week	2
Three or more times a week	3

#5b score _____

c score _____

d score _____

e score _____

f score _____

g score _____

h score _____

i score _____

j score _____

(2) Add the scores for questions # 5b-5j:

Sum of # 5b-5j: _____

(3) Assign component 5 score as follows:

Sum of # 5b-5j	Component 5 score
0	0
1-9	1
10-18	2
19-27	3

Component 5 score: _____

Component 6: Use of sleeping medication

Examine question # 7 and assign scores as follows:

Response	Component 6 score
Not during the past month	0
Less than once a week	1
Once or twice a week	2
Three or more times a week	3

Component 6 score: _____

Component 7: Daytime dysfunction

(1) Examine question # 8, and assign scores as follows:

Response	Score
Never	0
Once or twice	1
Once or twice each week	2
Three or more times each week	3

Question # 8 score: _____

(2) Examine question # 9, and assign scores as follows:

Response	Score
No problem at all	0
Only a very slight problem	1
Somewhat of a problem	2
A very big problem	3

Question # 9 score: _____

(3) Add the scores for question # 8 and # 9:

Sum of #8 and #9: _____

(4) Assign component 7 score as follows:

Sum of # 8 and #9	Component 7 score
0	0
1-2	1
3-4	2
5-6	3

Component 7 score: _____

Global PSQI Score

Add the seven component scores together:

Global PSQI Score: _____

L. Stanford Sleepiness Scale

Stanford Sleepiness Scale

This is a quick way to assess how alert you are feeling. If it is during the day when you go about your business, ideally you would want a rating of a one. Take into account that most people have two peak times of alertness daily, at about 9 a.m. and 9 p.m. Alertness wanes to its lowest point at around 3 p.m.; after that it begins to build again. Rate your alertness at different times during the day. If you go below a three when you should be feeling alert, this is an indication that you have a serious sleep debt and you need more sleep.

An Introspective Measure of Sleepiness
The Stanford Sleepiness Scale (SSS)

Degree of Sleepiness	**Scale Rating**
Feeling active, vital, alert, or wide awake	1
Functioning at high levels, but not at peak; able to concentrate	2
Awake, but relaxed; responsive but not fully alert	3
Somewhat foggy, let down	4
Foggy; losing interest in remaining awake; slowed down	5
Sleepy, woozy, fighting sleep; prefer to lie down	6
No longer fighting sleep, sleep onset soon; having dream-like thoughts	7
Asleep	X

M. Functional Outcomes of Sleep Questionnaire

Relevant Questions:

This is the **FOSQ** Questionnaire. (Functional Outcomes of Sleep Questionnaire)
Note: In this questionnaire the words "sleepy" or "tired" are used, it describes the feeling that you can't keep your eyes open, your head is droopy, that you want to nod off or that you feel the urge to take a nap. These words do not refer to the tired or fatigued feeling you may have after you have exercised.

FOSQ question are answered using numbers from 0-4.

- 0 = I don't do this activity for other reasons
- 1=Yes, extreme
- 2=Yes, moderate
- 3=Yes, a little
- 4=No

Q1 - Do you generally have difficulty concentrating on the things you do because you are sleepy or tired ?

Q2 - Do you generally have difficulty remembering things because you are sleepy or tired ?

Q3 - Do you have difficulty finishing a meal because you become sleepy or tired ?

Q4 - Do you have difficulty working on a hobby (for example: sewing,collecting,gardening) because you are sleepy and tired?

Q5 - Do you have difficulty doing work around the house (for example:cleaning house, doing laundry, taking out the trash, repair work) because you are sleepy or tired?

Q6 - Do you have difficulty operating a motor vehicle for short distances (**less** than 100 miles) because you become sleepy or tired?

Q7 - Do you have difficulty operating a motor vehicle for long distances (**greater** than 100 miles) because you become sleepy or tired?

Q8 - Do you have difficulty getting things done because you are too sleepy or tired to drive or take public transportation?

Q9 - Do you have difficulty taking care of financial affairs and doing paperwork (for example: writing checks, paying bills, keeping financial records, filling out tax forms , etc.) because you are sleepy or tired.

Q10 - Do you have difficulty performing employed or volunteer work because you are sleepy or tired?

Q12 - Do you have difficulty visiting with your family or friends in **your** home because you become sleepy or tired?

Q13 - Do you have difficulty visiting your family or friends in **their** home because you become sleepy or tired?

Q14 - Do you have difficulty doing things for your family or friends because you are too sleepy or tired?

Q15 - For question 15 answer using only 1,2,3 or 4. Has your relationship with family, friends or work colleagues been affected because you are sleepy pr tired?

Q16 - Do you have difficulty exercising or participating in a sporting activity because you are too sleepy or tired?

Q17 - Do you have difficulty watching movie or videotape because you become sleepy or tired?

Q18 - Do you have difficulty enjoying the theatre or a lecture because you become sleepy or tired?

Q19 - Do you have difficulty enjoying a concert because you become sleepy or tired?

Q20 - Do you have difficulty watching television because you are sleepy or tired?

Q21 - Do you have difficulty participating in religious services, meetings or a group or club because you are sleepy or tired?

Q22 - Do you have difficulty being as active as you want to be in the **evening** because you are sleepy or tired?

Q23 - Do you have difficulty being as active as you want to be in the **morning** because you are sleepy or tired?

Q24 - Do you have difficulty being as active as you want to be in the **afternoon** because you are sleepy or tired?

Q25 - Do you have difficulty keeping pace with others you own age because you are sleepy or tired?

Q26 - For question 25, answer only using the scale 1 = very low, 2=low, 3=medium, 4= high.
How would you rate your general activity?

Q27 - Has your intimate or sexual relationship been affected because you are sleepy or tired?

Q28 - Has you desire for intimacy or sex been affected because you are sleepy or tired?

Q29 - Has your ability to become sexually aroused been affected because you are sleepy or tired?

Q30 - Has your ability to have an orgasm been affected because you are sleepy or tired?

Appendix IV.

Quick Links to

Population-Based Studies

Questions from Large-Sample Sleep Studies

Questions From Sleep Scales and Questionnaires

I-A. American Time Use Survey Questionnaire

Homepage: http://www.bls.gov/tus/

Questionnaire: http://www.bls.gov/tus/tuquestionnaire.pdf
Section 4: Diary—Pages 18–20

I-B. Behavioral Risk Factor Surveillance System State Questionnaire

Homepage: http://www.cdc.gov/brfss/

Questionnaires: http://www.cdc.gov/brfss/questionnaires/index.htm

Relevant Questions: Module 7: Quality of Life:
http://apps.nccd.cdc.gov/brfssQuest/DisplayV.asp?PermID=339&startpg=1&endpg=1&TopicID=27&text=sleep&Join=OR&FromYr=Any&ToYr=Any

Behavioral Risk Factor Questionnaire, 2001:
http://www.cdc.gov/brfss/questionnaires/pdf-ques/2001brfss.pdf
Module 3: Quality of Life and Care Giving—Page 42
Module 7: Asthma History—Page 54

Behavioral Risk Factor Questionnaire, 2002:
http://www.cdc.gov/brfss/questionnaires/pdf-ques/2002brfss.pdf
Pages 68–69

I-C. CDC Pregnancy Risk Assessment Monitoring System 1999 Surveillance Report

Homepage: http://www.cdc.gov/reproductivehealth/PRAMS/

Questionnaire: http://www.cdc.gov/PRAMS/PDFs/1999PRAMSsurv.pdf

I-D. Fatality Analysis Reporting System

Homepage: http://www-fars.nhtsa.dot.gov

Query: Create a Query
http://www-fars.nhtsa.dot.gov/queryReport.cfm?stateid=0&year=2004

I-E. Framingham Heart Study

Homepage: http://www.nhlbi.nih.gov/about/framingham/index.html

Questionnaire: http://www.nhlbi.nih.gov/about/framingham/ex_forms.htm

Cohort Data Collection Forms: http://www.nhlbi.nih.gov/about/framingham/ex24pw_t.pdf
Page 26

Offspring Data Collections Forms: CES-D Scale
http://www.nhlbi.nih.gov/about/framingham/ex6pww7.pdf
Page 17

I-F. Global School-Based Survey 2004 Core Questionnaire

Homepage: http://www.cdc.gov/gshs/index.htm

Questionnaire: http://www.cdc.gov/gshs/questionnaire/index.htm
Click on "Core Questions."
Relevant Question: Mental Health Section: http://www.cdc.gov/gshs/pdf/2005Core.pdf
Page 8

I-G. National Asthma Survey, 2003

Homepage: http://www.cdc.gov/nchs/about/major/slaits/nsa.htm

Questionnaire: http://www.cdc.gov/nchs/data/slaits/revised_nas2003_national_specs.pdf

Section 4. History of Asthma (Symptoms & Episodes):
http://www.cdc.gov/nchs/data/slaits/revised_nas2003_national_specs.pdf
Page 12

I-H. National Comorbidity Survey, 1990–1992

Homepage: http://www.hcp.med.harvard.edu/ncs

Questionnaire: http://www.hcp.med.harvard.edu/ncs/ftpdir/Baseline%20NCS.pdf
A6—Page 11, B103—Page 45, B103p—Page 45, D9—Page 55, D10—Page 55, D11—Page 55, D15—Page 55, E11—Page 83, U31—Page 307, X3—Page 319, X3d—Page 319, X8—Page 320, X8a—Page 320, X13—Page 321, X29—Page 325, X34—Page 326, X34a—Page 326, X39—Page 327

I-I. National Health Interview Survey, 2002

Homepage: http://www.cdc.gov/nchs/nhis.htm

Family Questionnaire:
ftp://ftp.cdc.gov/pub/Health_Statistics/NCHS/Survey_Questionnaires/NHIS/2002/qfamilyx.pdf
Page 38

Module: Adult Core Questionnaire
Section: Conditions
ftp://ftp.cdc.gov/pub/Health_Statistics/NCHS/Survey_Questionnaires/NHIS/2002/qsamadlt.pdf
Page 7

Module: Child Core Questionnaire
Section: Part B, Mental Health
ftp://ftp.cdc.gov/pub/Health_Statistics/NCHS/Survey_Questionnaires/NHIS/2002/qsamchld.pdf
Page 11

2002 Variable Supplement: Alternative Medicine
http://wonder.cdc.gov/wonder/sci%5Fdata/surveys/nhis/type%5Ftxt/nhis2002/althealt.pdf
Pages 8 and 9

I-J. National Health and Nutrition Examination Survey

Homepage: http://www.cdc.gov/nchs/nhanes.htm

I-K. National Household Survey on Drug Abuse

Homepage: http://www.oas.samhsa.gov/nhsda.htm

Questionnaire: http://www.oas.samhsa.gov/nhsda/2k1CAI/2001_CAI_Specs_W.pdf
DRALC11—Page 140, DRALC12—Pages 140–141, DRCC11—Page 146, DRCC12—Page 146, DRHE11—Pages 148–149, DRHE12—Page 149, DRPR11—Page 156, DRPR12—Page 156, DRST11—Page 161, DRST12—Pages 161–162, DRSV11—Page 164, DRSV12—Pages 164–165, DEFEELPR—Pages 224–225, DELOSTPR—Page 225, MASLEEP—Page 225, GAPROB—Page 229, PTREACT—Page 229–230

I-L. National Sleep Foundation, Sleep in America Poll

Homepage: http://www.sleepfoundation.org/hottopics/index.php?secid=16

Questionnaire:
http://www.sleepfoundation.org/_content/hottopics/2005_summary_of_findings.pdf

I-M. National Survey of Children's Health, 2003

Homepage: http://www.cdc.gov/nchs/about/major/slaits/nsch.htm

Questionnaire: http://www.cdc.gov/nchs/data/slaits/NSCH_Questionnaire.pdf
Page 39 of 65

I-N. National Survey of Early Childhood Health

Homepage: http://www.cdc.gov/nchs/about/major/slaits/nsech.htm

Questionnaire: http://www.cdc.gov/nchs/data/slaits/survey_sech00.pdf
Section 3: Interactions with Health Care Providers
A3Q03 (13A-c)—Page 58, A3Q03_A (13A-c-iii)—Page 59, A3Q14 (13B-c)—Page 62, A3Q14_A (13B-c-iii)—Page 62

I-O. Nurses' Health Study

Homepage: http://www.channing.harvard.edu/nhs/index.html

2001 Questionnaire:
http://www.channing.harvard.edu/nhs/questionnaires/pdfs/NHSII/2001.PDF
Questions 12, 13, 15 on page 2 of Questionnaire, and Question 42 on page 5 of Questionnaire

2002 Questionnaire:
http://www.channing.harvard.edu/nhs/questionnaires/pdfs/NHSI/2002.PDF
Questions 2 and 3 on page 1 of Questionnaire

I-P. United Nations General Social Survey, Cycle 12: Time Use

Homepage: http://unstats.un.org/unsd/demographic/sconcerns/tuse/default.aspx

Questionnaire:
http://unstats.un.org/unsd/methods/timeuse/tusresource_instruments/canada_instr.pdf
Exception 1—Page 7, Exception 2—Page 7, Part D2—Page 14, Part F—Page 31, Part L—Page 67

I-Q. U.S. Department of Labor, Bureau of Labor Statistics: National Longitudinal Survey

Home Page: http://www.bls.gov/nls/

Time Use Questionnaire: http://www.bls.gov/nls/quex/y97r3timeuse.pdf

Health Questionnaire: http://www.bls.gov/nls/79quex/r19/y79r19health.pdf
Q11-H40CESD-1E—Page 15 of 32, Q11-H40CHRC-10bb—Page 28 of 32

I-R. Department of Veterans Affairs Databases

Homepage: http://www.virec.research.med.va.gov/

I-S. National Hospital Discharge Survey

Homepage: http://www.cdc.gov/nchs/about/major/hdasd/nhdsdes.htm

Data Description: http://www.cdc.gov/nchs/data/series/sr_01/sr01_039.pdf

I-T. National Vital Statistics System

Homepage: http://www.cdc.gov/nchs/nvss.htm

I-U. Women's Health Initiative

Homepage: http://www.whiscience.org

Variable List: http://www.whiscience.org/data/

Form 37—Thoughts and Feelings:
http://www.whiscience.org/data/dd_form/f37_dd.pdf
Pages 49 to 52

I-V. Sleep Heart Health Study (SHHS)

Homepage: http://www.jhucct.com/shhs/default.html

Questionnaire: http://www.jhucct.com/shhs/manual/documen.htm

Framingham:
http://www.jhucct.com/shhs/manual/forms/hi/shhshif.pdf

New York:
http://www.jhucct.com/shhs/manual/forms/hi/shhshin.pdf

ARIC, CHS, Tucson/Strong Heart:
http://www.jhucct.com/shhs/manual/forms/hi/shhshia.pdf

Sleep Data—Quality Assessment and Preliminary Report:
http://www.jhucct.com/shhs/manual/forms/qa/shhsqa6.pdf

I-W. National Ambulatory Medical Care Survey

Homepage: http://www.cdc.gov/nchs/about/major/ahcd/namcsdes.htm

II-A. Corporate British Health Questionnaire

Pub-Med Abstract
http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?db=pubmed&cmd=Retrieve&dopt=AbstractPlus&list_uids=15679885&query_hl=11&itool=pubmed_docsum
(NOTE: Some publisher websites provide free access to full text documents. Others require subscription or fee)

Questionnaire
http://www.ehjournal.net/content/supplementary/1476-069X-4-1-S1.doc

II-B. Chronic Fatigue Syndrome and Sleep Assessment

Pub-Med Abstract
http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?db=pubmed&cmd=Retrieve&dopt=AbstractPlus&list_uids=15096280&query_hl=17&itool=pubmed_docsum
(NOTE: Some publisher websites provide free access to full text documents. Others require subscription or fee)

Questionnaire
http://www.biomedcentral.com/content/supplementary/1471-2377-4-6-S1.doc

II-C. Daytime Sleepiness and Hyperactive Children

Pub-Med Abstract
http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?db=pubmed&cmd=Retrieve&dopt=AbstractPlus&list_uids=15342852&query_hl=7&itool=pubmed_docsum
(NOTE: Some publisher websites provide free access to full text documents. Others require subscription or fee)

Conners Abbreviated Symptom Questionnaire
http://pediatrics.aappublications.org/cgi/content-nw/full/114/3/768/T5

II-D. Nursing Home Quality Initiative

Main Web Portal: http://www.cms.hhs.gov/NursingHomeQualityInits/

Minimum Data Set (MDS) For Nursing Home Resident Assessment and Care Screening:
http://www.cms.hhs.gov/NursingHomeQualityInits/downloads/MDS20MDSAllForms.pdf
Relevant Pages: 4, 13, 16, 20, 31

II-E. Older Adults and Arthritis

Pub-Med Abstract
http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?db=pubmed&cmd=Retrieve&dopt=AbstractPlus&list_uids=14720300&query_hl=24&itool=pubmed_docsum
(NOTE: Some publisher websites provide free access to full text documents. Others require subscription or fee)

Questionnaire http://www.hqlo.com/content/supplementary/1477-7525-2-5-S1.doc

II-F. Pediatric Sleep Medicine Survey

Pub-Med Abstract
http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?db=pubmed&cmd=Retrieve&dopt=AbstractPlus&list_uids=11533369&query_hl=26&itool=pubmed_docsum
(NOTE: Some publisher websites provide free access to full text documents. Others require subscription or fee)

Survey http://pediatrics.aappublications.org/cgi/content/full/108/3/e51#Fu2

II-G. Reduction in Tinnitus Severity

Pub-Med Abstract
http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?db=pubmed&cmd=Retrieve&dopt=AbstractPlus&list_uids=12234379&query_hl=28&itool=pubmed_docsum
(NOTE: Some publisher websites provide free access to full text documents. Others require subscription or fee)

Survey http://www.biomedcentral.com/content/supplementary/1472-6815-2-3-S1.doc

III-A. A.P.N.E.A. Net: The Apnea Patient's News, Education & Awareness Network

Sleep Apnea Questionnaire http://www.apneanet.org/question.htm

III-B. Epworth Sleepiness Scale

http://patients.uptodate.com/image.asp?file=pulm_pix/epworth_.htm

III-C. Exempla Healthcare Sleep Disorders Laboratory: Patient Education and Screening Questionnaire

http://www.exempla.org/care/services/sleep/docs/PtQuestionnaire.pdf

III-D. Infant Screening Questionnaire

Pub-Med Abstract
http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?db=pubmed&cmd=Retrieve&dopt=AbstractPlus&list_uids=15173539&query_hl=33&itool=pubmed_DocSum
(NOTE: Some publisher websites provide free access to full text documents. Others require subscription or fee)

BISQ-Questionnaire
http://pediatrics.aappublications.org/cgi/content/full/113/6/e570

III-E. Leeds Sleep Evaluation Questionnaire

Pub-Med Abstract
http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?itool=abstractplus&db=pubmed&cmd=Retrieve&dopt=abstractplus&list_uids=12532311

(NOTE: Some publisher websites provide free access to full text documents. Others require subscription or fee)

Questionnaire
http://www.medscape.com/content/2004/00/47/52/475272/art-cmro475272.app2.gif

III-F. Maternal Child Supervision Questionnaire, 1961

Pub-Med Abstract
http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?db=pubmed&cmd=Retrieve&dopt=AbstractPlus&list_uids=13742227&query_hl=44&itool=pubmed_docsum

(NOTE: Some publisher websites provide free access to full text documents. Others require subscription or fee)

III-G. Parental Interactive Bedtime Behavior Scale

Wiley InterScience Abstract
http://www3.interscience.wiley.com/cgi-bin/abstract/91513564/ABSTRACT

(NOTE: Some publisher websites provide free access to full text documents. Others require subscription or fee)

Instrument: http://www3.interscience.wiley.com/cgi-bin/fulltext/91513564/PDFSTART

III- H. Pediatric Sleep Questionnaire

Questionnaire http://www.saintpatrick.org/images/sleep_questionnaire.pdf

III-I. Sinai Hospital Sleep Disorder Assessment Questionnaire

Questionnaire http://www.lifebridgehealth.org/pdf/inst1.pdf

II-J. Sleep Apnea—The Phantom of the Night Questionnaire

Questionnaire http://www.healthyresources.com/sleep/apnea/question/quiz.html

III-K. Pittsburgh Sleep Quality Index

Pub-Med Abstract
http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&list_uids=2748771&dopt=Abstract
(NOTE: Some publisher websites provide free access to full text documents. Others require subscription or fee)

Instrument http://www.cs.nsw.gov.au/rpa/sdc/source/PITTSBURGH%20SLEEP%20QUALITY%20INDEX.pdf

III-L. Stanford Sleepiness Scale

Instrument http://www.stanford.edu/%7Edement/sss.html

III-M. Functional Outcomes of Sleep Questionnaire

Instrument http://www.sleep-pros.net/fosq_test.htm