

Appendices

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Quick Links to Population-Based Studies

The appendices contain selected questions 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.

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Appendix I.

Relevant Questions From National Studies

Table of Contents

A. American Time Use Survey Questionnaire, 2004	6
B. Behavioral Risk Factor Surveillance System State Questionnaire.....	8
C. CDC Pregnancy Risk Assessment Monitoring System 1999 Surveillance Report.....	11
D. Fatality Analysis Reporting System.....	11
E. Framingham Heart Study	12
F. Global School-Based Survey 2004 Core Questionnaire.....	15
G. National Asthma Survey, 2003	16
H. National Comorbidity Survey, 1990–1992	17
I. National Health Interview Survey, 2002	20
J. National Health and Nutrition Examination Survey	26
K. National Household Survey on Drug Abuse.....	27
L. National Sleep Foundation, Sleep in America Poll	33
M. National Survey of Children’s Health, 2003	53
N. National Survey of Early Childhood Health	54
O. Nurses’ Health Study	55
P. United Nations General Social Survey, Cycle 12: Time Use.....	55
Q. U.S. Department of Labor, Bureau of Labor Statistics: National Longitudinal Survey	57
R. Department of Veterans Affairs Databases.....	57
S. National Hospital Discharge Survey	57
T. National Vital Statistics System.....	57
U. Women’s Health Initiative.....	58
V. Sleep Heart Health Study (SHHS).....	62
W. National Ambulatory Medical Care Survey.....	68

A. American Time Use Survey Questionnaire

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.

See Next Page

CORE_LEAD**Universe:** All

Now I'd like to find out how you spent your time yesterday, [yesterday's day & date], from 4:00 in the morning until 4:00 am this morning. I'll need to know where you were and who else was with you. If an activity is too personal, there's no need to mention it.

The following variables are included in the diary grid:

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 | 30. Don't know/ Can't remember |
| 2. Grooming (self) | 31. Refusal/ None of your business |
| 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] |

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]

B. Behavioral Risk Factor Surveillance System State Questionnaire

See Next Page

Historical Questions Detail

C = Core Question **M** = Module Question

Quality Of Life

During the past 30 days, for about how many days have you felt you did not get enough rest or sleep? (Screened for physical, mental, emotional problems or use of special equipment because of a health problem.)

Variable Name: QLREST2

____=Number of days

88=None

77=DK/NS

99=Refused

2002 - M, 2001 - M

During the past 30 days, for about how many days have you felt you did not get enough rest or sleep?

Variable Name: QLREST

____=Number of days

88=None

77=DK/NS

99=Refused

2000 - M, 1999 - M, 1998 - M, 1997 - M, 1996 - M, 1995 - M

DK/NS = Don't Know/Not Sure

C = Core Question **M** = Module Question

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 6: Quality of Life

10. During the past 30 days, for about how many days have you felt you did not get enough rest or sleep? (252-253)

__	__	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 7 Don't know/Not sure
these responses 9 Refused

Module 16: Effects of September 11th Attacks

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

Questionnaire: <http://www.cdc.gov/PRAMS/PDFs/1999PRAMSurv.pdf>
page 399 Question 45

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

D. Fatality Analysis Reporting System (FARS)

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

See Next Page

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.

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

Offspring Data Collection Forms:

The Offspring Data Collection Forms, as the 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.

Second Examiner -- Cerebrovascular and Neurological History and Opinions

Cerebrovascular Episodes in Interim	
<input type="checkbox"/>	Sudden muscular weakness
<input type="checkbox"/>	Sudden speech difficulty
<input type="checkbox"/>	Sudden visual defect
<input type="checkbox"/>	Double vision
<input type="checkbox"/>	Loss of vision in one eye
<input type="checkbox"/>	Unconsciousness
<input type="checkbox"/>	Numbness, tingling
<input type="checkbox"/>	Numbness and tingling is positional

**Code: 0=No,
1=Yes,
2=Maybe,
9=Unknown**

**if yes,
fill**

Details for "Serious" Cerebrovascular Event in Interim	
<input type="checkbox"/> 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) <div style="text-align: center; margin-top: 5px;"> <input type="text"/> <input type="text"/> * <input type="text"/> <input type="text"/> </div>
	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 _____

CES-D Scale

6|0|0|0|8 FORM NUMBER

<input style="width: 100%; height: 100%;" type="text"/>	Nurse Examiner's Number
---	--------------------------------

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
1. I was bothered by things that usually don't bother me.	0	1	2	3	9
2. I did not feel like eating; my appetite was poor.	0	1	2	3	9
3. I felt that I could not shake off the blues, even with help from my family and friends.	0	1	2	3	9
4. I felt that I was just as good as other people.	0	1	2	3	9
5. I had trouble keeping my mind on what I was doing.	0	1	2	3	9
6. I felt depressed.	0	1	2	3	9
7. I felt that everything I did was an effort.	0	1	2	3	9
8. I felt hopeful about the future.	0	1	2	3	9
9. I thought my life had been a failure.	0	1	2	3	9
10. I felt fearful.	0	1	2	3	9
11. My sleep was restless.	0	1	2	3	9
12. I was happy.	0	1	2	3	9
13. I talked less than usual.	0	1	2	3	9
14. I felt lonely.	0	1	2	3	9
15. People were unfriendly.	0	1	2	3	9
16. I enjoyed life.	0	1	2	3	9
17. I had crying spells.	0	1	2	3	9
18. I felt sad.	0	1	2	3	9
19. I felt that people disliked me.	0	1	2	3	9
20. I could not "get going"	0	1	2	3	9

F. Global School-Based Survey 2004 Core Questionnaire

GSBS Core Questionnaire Mental Health Module

2. 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

Section 4: History of Asthma (Symptoms & Episodes)

ASLEEP20 (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

See Next Page

SECTION A: ACTIVITIES OF DAILY LIFE

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.

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

SECTION D: SADNESS

D9. Have you ever had 2 weeks or more when nearly every night you had trouble falling asleep?

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

D11. Have you ever had 2 weeks or more when nearly every night you had trouble staying asleep?

D12. Did you ever have 2 weeks or more when nearly every night you lay awake more than one hour?

D13. Have you ever had 2 weeks or more when nearly every morning you woke up too early?

D14. Have you ever had 2 weeks or more when nearly every morning you would wake up at least 2 hours before you wanted to?

D15. Have you ever had 2 weeks or longer when nearly every day you were sleeping too much?

SECTION E: MANIA

E11. Has there ever been a period when you hardly slept at all but still did not feel tired or sleepy?

SECTION G: MEDICATIONS AND DRUGS

S50. (RB, P. 37) Please turn to Page 37 in the Yellow Booklet. In the past 12 months, did you take any of the following types of prescription medications under the supervision of a doctor, for your emotions or nerves or your use of alcohol or drugs?

A. SLEEPING PILLS OR
 OTHER SEDATIVES
(HALCION, DALMANE)

SECTION U: LIFE EVENT HISTORY

The next questions are about events that may have happened in your lifetime. For these questions please give me your answer and then circle the question number if the event has happened to you.

U31. Did you have more trouble sleeping than is usual for you?

SECTION X: FAMILY HISTORY

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?

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?

I. National Health Interview Survey, 2002

See Next Page

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

[]

[]

ACN.125.060 DURING THE PAST 12 MONTHS have you ...

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

>INSOMYR< ... regularly had insomnia or trouble sleeping?

>FATIGYR< ... regularly had excessive sleepiness during the day?

>PAINYR< ... had recurring pain?

Part B - Mental Health

Check item CHSCCI3: If AGE = 4-17 go to CMHMF11;
If AGE = 2-3 & SEX is male, then goto CHS.321;
If AGE = 2-3 & SEX is female, then, goto CHS.361;

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

HE:

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

(Go to CAU.020)

ALT - 9
 2002 NATIONAL HEALTH INTERVIEW SURVEY
 ALTERNATIVE HEALTH/COMPLEMENTARY AND ALTERNATIVE MEDICINE - PUBLIC USE
 31,044 RECORDS

Variable Name	Question	Section modified 06/11/03
Question No.	Variable Universe	
	Universe Description	
Location	Variable Label	
Freq.	Value / Value Labels	

ACUCON21-40 For what health problems or conditions did you use acupuncture?

ALT.005

ASTATFLG = 1, AGE = 18+ and ACU_EVER = 1 and
 ACU_USEM = 1 and ACU_TRET = 1

Sample adults 18+ who have seen a practitioner for acupuncture during the past 12 months and have used acupuncture to treat a specific health problem or condition

51-70

REFER TO THE TABLE BELOW

VARIABLE NAME	VARIABLE LABEL	Mentioned 1	Not mentioned 2
ACUCON21	Excessive sleepiness during the day	1	270
ACUCON22	Jaw pain	0	271
ACUCON23	Fracture, bone/joint injury	8	263
ACUCON24	Glaucoma	0	271
ACUCON25	Gynecologic problems	2	269
ACUCON26	Hay fever	7	264
ACUCON27	Hearing problem	1	270
ACUCON28	Heart attack	0	271
ACUCON29	Heart condition or disease	1	270
ACUCON30	Hernia	0	271
ACUCON31	Hypertension	1	270
ACUCON32	Irregular heartbeat	0	271
ACUCON33	Knee prob (not arthritis or joint inj)	2	269
ACUCON34	Lung/breathing problem	0	271
ACUCON35	Macular degeneration	0	271
ACUCON36	Menopause	3	268
ACUCON37	Menstrual problems	4	267
ACUCON38	Mental retardation	0	271
ACUCON39	Joint pain or stiffness	32	239
ACUCON40	Missing limbs (fingers, toes, or digits)	1	270

Sources: None

Recodes: None

Keywords: acupuncture

NOTES: 7. Refused 4 8. Not ascertained 0 9. Don't know 1

ALT - 10
 2002 NATIONAL HEALTH INTERVIEW SURVEY
 ALTERNATIVE HEALTH/COMPLEMENTARY AND ALTERNATIVE MEDICINE - PUBLIC USE
 31,044 RECORDS

Variable Name	Question	Section modified
Question No.	Variable Universe	
Location	Universe Description	
	Variable Label	
Freq.	Value / Value Labels	

ACUCON41-60 For what health problems or conditions did you use acupuncture?

ALT.005

ASTATFLG = 1, AGE = 18+ and ACU_EVER = 1 and
 ACU_USEM = 1 and ACU_TRET = 1

Sample adults 18+ who have seen a practitioner for acupuncture during the past 12 months and have used acupuncture to treat a specific health problem or condition

71-90

REFER TO THE TABLE BELOW

VARIABLE NAME	VARIABLE LABEL	Mentioned 1	Not mentioned 2
ACUCON41	Multiple sclerosis	0	271
ACUCON42	Neuropathy	3	268
ACUCON43	Osteoporosis, tendinitis	0	271
ACUCON44	Other developmental problem	0	271
ACUCON45	Other injury	1	270
ACUCON46	Other nerve damage, including CTS	2	269
ACUCON47	Parkinson's	0	271
ACUCON48	Polio (myelitis), paralysis, para/quad	0	271
ACUCON49	Poor circulation in your legs	1	270
ACUCON50	Insomnia or trouble sleeping	5	266
ACUCON51	Liver problem	0	271
ACUCON52	Dental pain	1	270
ACUCON53	Prostate trouble or impotence	0	271
ACUCON54	Seizures	0	271
ACUCON55	Senility	0	271
ACUCON56	Sinusitis	6	265
ACUCON57	Skin problems	5	266
ACUCON58	Sprain or strain	4	267
ACUCON59	Stroke	0	271
ACUCON60	Text of first other specify	2	269

Sources: None

Recodes: None

Keywords: acupuncture

NOTES: 7. Refused 4 8. Not ascertained 0 9. Don't know 1

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

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

See Next Page

Source Documentation can be found online at:

Questionnaire: http://www.oas.samhsa.gov/nhsda/2k1CAI/2001_CAI_Specs_W.pdf

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

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

L. National Sleep Foundation, Sleep in America Poll 2005

'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)	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

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,
- 04 4 or 5 times, or **↗ CONTINUE**
- 05 More than 5 times?
- 98 **DO NOT READ:** Refused
- 99 **DO NOT READ:** Don't know **↗ SKIP TO Q14**

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 **↻ SKIP TO Q51**

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,
- 04 A student,
- 05 A homemaker,
- 06 Unemployed,
- 07 Retired,
- 08 Disabled, or a

☞ **CONTINUE**

D1

- 09 Volunteer?
- 95 **DO NOT READ:** Other **(SPECIFY):** _____
- 98 **DO NOT READ:** Refused
- 99 **DO NOT READ:** Don't know

☞ **SKIP TO**

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:

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 last 12 months/ 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

002

Question 2

Question 3

2004

Question 55

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

Relevant Questions:

Section B: Time Use Diary

We need accurate information on the way people use their time and the best way is to complete a diary listing of all of your activities over a 24-hour period. We start our diary at 4:00 in the morning because most of the people are asleep at that time.

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

Section C: Questions about the Designated Day

- C5 When did your child/children go to sleep on [CATI - Interviewer: print designated day]?**
(Children less than 15)
(Interviewer: Record the time of the child who went to sleep last)

Section D: Perceptions of Time

- D1 Now I would like to ask you some questions on your outlook towards your use of time.**

- 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

Section F: Work and education

- F48 Are you satisfied or dissatisfied with the balance between your job and home life ?**

- 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

Section L: Other classification

- 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

Q11-H40CESD-1E
[R68981.00]

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

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

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 |

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	%	Source Forms: 27
1 No, not in past 4 weeks	93,997	55.1%	Usage Notes: none
2 Yes, less than once a week	39,729	19.4%	
3 Yes, 1 or 2 times a week	26,726	12.6%	
4 Yes, 3 or 4 times a week	3,462	5.9%	
5 Yes, 5 or more times a week	5,402	4.0%	
Missing	1,447	0.9%	
	168,797		

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	%	Source Forms: 27
1 No, not in past 4 weeks	38,061	47.0%	Usage Notes: none
2 Yes, less than once a week	35,619	22.0%	
3 Yes, 1 or 2 times a week	27,361	17.2%	
4 Yes, 3 or 4 times a week	13,666	8.5%	
5 Yes, 5 or more times a week	7,325	4.5%	
Missing	1,332	0.8%	
	168,797		

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	%	Source Forms: 27
1 No, not in past 4 weeks	32,955	20.4%	Usage Notes: none
2 Yes, less than once a week	7,560	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	16,367	11.5%	
6 Don't know	92,751	51.1%	
Missing	1,312	0.8%	
	168,797		



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	%	Source Form: 27
0	Rarely or none of the time	50,361	42.2%	Usage Notes: none
1	Sometimes or a little of the time	58,052	48.9%	
2	Occasionally or a moderate amount	21,358	17.9%	
3	Most or all of the time	10,126	8.5%	
	Missing	1,458	1.2%	
		101,767		

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	%	Source Form: 27
1	No, not in past 4 weeks	20,641	24.6%	Usage Notes: none
2	Yes, less than once a week	36,278	43.4%	
3	Yes 1 or 2 times a week	41,622	50.0%	
4	Yes 3 or 4 times a week	25,125	30.1%	
5	Yes 5 or more times a week	16,524	19.9%	
	Missing	1,176	1.4%	
		83,767		

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	%	Source Form: 27
0	No, not in past 4 weeks	122,162	75.5%	Usage Notes: none
1	Yes, less than once a week	14,507	9.2%	
2	Yes 1 or 2 times a week	9,969	6.3%	
3	Yes 3 or 4 times a week	4,969	3.1%	
4	Yes 5 or more times a week	10,131	6.3%	
	Missing	1,421	0.9%	
		163,159		



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	%	Source Form: 37
1 No, not in past 4 weeks	35,194	31.8%	Usage Notes: none
2 Yes, less than once a week	27,334	26.9%	
3 Yes, 1 or 2 times a week	34,153	31.1%	
4 Yes, 3 or 4 times a week	28,313	17.7%	
5 Yes, 5 or more times a week	28,951	21.6%	
Missing	1,442	0.9%	
	101,287		

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	%	Source Form: 37
1 5 or less hours	13,304	8.4%	Usage Notes: none
2 6 hours	44,264	27.4%	
3 7 hours	60,241	37.2%	
4 8 hours	35,726	22.1%	
5 9 hours	4,206	2.8%	
6 10 or more hours	826	0.5%	
Missing	828	0.5%	
	159,792		

F37 Typical nights sleep

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

Values	N	%	Source Form: 37
1 Very restless	3,626	2.2%	Usage Notes: none
2 Restless	32,732	18.9%	
3 Average quality	67,627	41.8%	
4 Sound or restless	46,951	28.5%	
5 Very sound or restless	20,736	12.8%	
Missing	942	0.6%	
	169,720		



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	%	Source Form: 37
1 No, not in past 4 weeks	37,725	48.0%	Usage Notes: none
2 Yes, less than once a week	32,296	20.0%	
3 Yes, 1 or 2 times a week	26,868	18.9%	
4 Yes, 3 or 4 times a week	14,162	8.8%	
5 Yes, 5 or more times a week	9,358	5.4%	
Missing	1,381	0.9%	
	161,757		

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	%	Source Form: 37
1 No, not in past 4 weeks	66,246	40.9%	Usage Notes: none
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	11,038	7.2%	
Missing	1,357	0.8%	
	161,757		

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 exclude the time you spend sleeping or trying to sleep at night, reading or napping, and lying down watching TV.

Values	N	%	Source Form: 42
1 Less than 4 hours	5,970	5.4%	Usage Notes: none
2 4-5 hours	2,905	5.1%	
3 6-7 hours	10,440	27.7%	
4 8-9 hours	42,332	45.2%	
5 10-11 hours	12,733	13.4%	
6 12-13 hours	2,739	3.8%	
7 14-15 hours	585	0.6%	
8 16 or more hours	277	0.3%	
Missing	626	0.7%	
	93,698		

V. Sleep Heart Health Study (SHHS)

See Next Page



SLEEP HEART HEALTH STUDY

1st Follow-up

SLEEP HABITS QUESTIONNAIRE

ID#:

Field Center: _____

Today's date: _____
month day year

Please complete as thoroughly as possible and to the best of your knowledge.

1 How many hours of sleep do you usually get at night (or your main sleep period) on weekdays or workdays?

_____ (Number of hours)

2 How many hours of sleep do you usually get at night (or your main sleep period) on weekends or your non-work days?

_____ (Number of hours)

3 During a usual week, how many times do you nap for 5 minutes or more? (Write in "0" if you do not take any naps.)

_____ (Number of times)

4 Please indicate how often you experience each of the following. (Check one box for each item.)

	NEVER (0)	RARELY (1/month or less)	SOMETIMES (2-4/month)	OFTEN (5-15/month)	ALMOST ALWAYS (16-30/month)
A. Have trouble falling asleep.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
B. Wake up during the night and have difficulty getting back to sleep.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
C. Wake up too early in the morning and be unable to get back to sleep.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
D. Feel unrested during the day, no matter how many hours of sleep you had.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
E. Do not get enough sleep.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
F. Take sleeping pills or other medication to help you sleep.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

Questions 5 through 11 are about snoring and breathing during sleep. To answer these questions, please consider both what others have told you AND what you know about yourself.

5 Have you ever snored (now or at any time in the past)?

- 1 YES 0 NO 8 DON'T KNOW
- ↓
- Skip to Question 9 below.

6 How often do you snore now? (Check one.)

- 0 Do not snore any more. → Skip to Question 8 below.
- 1 Rarely - less than one night a week.
- 2 Sometimes - 1 or 2 nights a week.
- 3 Frequently - 3 to 5 nights a week.
- 4 Always or almost always - 6 or 7 nights a week.
- 8 Don't know.

7 How loud is your snoring? (Check one.)

- 1 Only slightly louder than heavy breathing.
- 2 About as loud as mumbling or talking.
- 3 Louder than talking.
- 4 Extremely loud - can be heard through a closed door.
- 8 Don't know.

8 A. Since you had your sleep study, have you been treated for snoring?

- 1 YES 0 NO 8 DON'T KNOW
- ↓

B. If yes, what treatment(s) were prescribed?

- | YES | NO | |
|----------------------------|----------------------------|--|
| <input type="checkbox"/> 1 | <input type="checkbox"/> 0 | Lose weight |
| <input type="checkbox"/> 1 | <input type="checkbox"/> 0 | Reduce/stop drinking |
| <input type="checkbox"/> 1 | <input type="checkbox"/> 0 | Change sleeping position (sleep on side instead of back) |
| <input type="checkbox"/> 1 | <input type="checkbox"/> 0 | Use a mouthpiece |
| <input type="checkbox"/> 1 | <input type="checkbox"/> 0 | CPAP or BiCAP |
| <input type="checkbox"/> 1 | <input type="checkbox"/> 0 | Surgery (including laser) |
| <input type="checkbox"/> 1 | <input type="checkbox"/> 0 | Other: _____ |

9 Based on what you have noticed or household members have told you, are there times when you stop breathing during your sleep?

- 1 YES 0 NO → *Skip to Question 11 below.*
 8 DON'T KNOW →

10 How often do you have times when you stop breathing during your sleep?

- 1 Rarely - less than one night a week.
 2 Sometimes - 1 or 2 nights a week.
 3 Frequently - 3 to 5 nights a week.
 4 Always or almost always - 6 or 7 nights a week.
 8 Don't know.

11 A. Have you ever been told by a doctor that you had sleep apnea (a condition in which breathing stops briefly during sleep)?

- 1 YES ↓
 0 NO → *Skip to Question 12 on next page.*
 8 DON'T KNOW →

B. Since you had your SHHS sleep test, have you been treated for sleep apnea?

- 1 YES ↓
 0 NO ↓
 8 DON'T KNOW → *Skip to Question 12 on next page.*

C. If yes, what treatment(s) were prescribed?

- | YES | NO | |
|----------------------------|----------------------------|--|
| <input type="checkbox"/> 1 | <input type="checkbox"/> 0 | Lose weight |
| <input type="checkbox"/> 1 | <input type="checkbox"/> 0 | Reduce/stop drinking |
| <input type="checkbox"/> 1 | <input type="checkbox"/> 0 | Change sleeping position (sleep on side instead of back) |
| <input type="checkbox"/> 1 | <input type="checkbox"/> 0 | Use a mouthpiece |
| <input type="checkbox"/> 1 | <input type="checkbox"/> 0 | CPAP or BiCAP |
| <input type="checkbox"/> 1 | <input type="checkbox"/> 0 | Surgery (including laser) |
| <input type="checkbox"/> 1 | <input type="checkbox"/> 0 | Other: _____ |

D. If you were not treated, why not?

- 1 Doctor did not think necessary
 2 I did not want treatment
 3 Other: _____

12 Have you ever been told by a doctor that you had some other sleep disorder?

- 1 YES
 0 NO
 8 DON'T KNOW
- An arrow points from the "NO" and "DON'T KNOW" options to the text: *Skip to Question 13 below.*

Please specify: _____

13 Do you usually use oxygen therapy (oxygen delivered by a mask or nasal cannula) during your sleep?

- 1 YES
 0 NO

14 During the past year, how often have one or more members of your household been in or near the room where you have slept?

- 1 NEVER
 2 SOMETIMES
 3 USUALLY

15 What is the chance that you would doze off or fall asleep (not just "feel tired") in each of the following situations? (Check one box for each situation. If you are never or rarely in the situation, please give your best guess for that situation.)

	NO CHANCE	SLIGHT CHANCE	MODERATE CHANCE	HIGH CHANCE
A. Sitting and reading.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
B. Watching TV.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
C. Sitting inactive in a public place (such as a theater or a meeting).	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
D. Riding as a passenger in a car for an hour without a break.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
E. Lying down to rest in the afternoon when circumstances permit.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
F. Sitting and talking to someone.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
G. Sitting quietly after a lunch without alcohol.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
H. In a car, while stopped for a few minutes in traffic.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
I. At the dinner table.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
J. While driving.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4

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.....	71
B. Chronic Fatigue Syndrome and Sleep Assessment.....	79
C. Daytime Sleepiness and Hyperactive Children.....	81
D. Nursing Home Quality Initiative, 2004.....	82
E. Older Adults and Arthritis.....	84
F. Pediatric Sleep Medicine Survey.....	85
G. Reduction in Tinnitus Severity.....	92

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
<input type="checkbox"/>				
[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
<input type="checkbox"/>				
[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
<input type="checkbox"/>				
[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
<input type="checkbox"/>				
[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 |
| <input type="checkbox"/> |
| [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 |
| <input type="checkbox"/> |
| [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 through 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
<input type="checkbox"/>				
[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: Height: inches Weight: lbs.
 or cm 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				

D. Nursing Health Initiative Minimum Data Set

See Next Page - Section E-1 'Sleep Cycle Issues'

MDS QUARTERLY ASSESSMENT FORM

Numeric Identifier _____

A1.	RESIDENT NAME	a. (First) b. (Middle Initial) c. (Last) d. (Jr/Sr)
A2.	ROOM NUMBER	<input type="text"/>
A3.	ASSESSMENT REFERENCE DATE	a. Last day of MDS observation period <input type="text"/> — <input type="text"/> — <input type="text"/> Month Day Year b. Original (0) or corrected copy of form (enter number of correction)
A4a	DATE OF REENTRY	Date of reentry from most recent temporary discharge to a hospital in last 90 days (or since last assessment or admission if less than 90 days) <input type="text"/> — <input type="text"/> — <input type="text"/> Month Day Year
A6.	MEDICAL RECORD NO.	<input type="text"/>
B1.	COMATOSE	(Persistent vegetative state/no discernible consciousness) 0. No 1. Yes (Skip to Section G)
B2.	MEMORY	(Recall of what was learned or known) a. Short-term memory OK—seems/appears to recall after 5 minutes 0. Memory OK 1. Memory problem b. Long-term memory OK—seems/appears to recall long past 0. Memory OK 1. Memory problem
B4.	COGNITIVE SKILLS FOR DAILY DECISION-MAKING	(Made decisions regarding tasks of daily life) 0. INDEPENDENT—decisions consistent/reasonable 1. MODIFIED INDEPENDENCE—some difficulty in new situations only 2. MODERATELY IMPAIRED—decisions poor; cues/supervision required 3. SEVERELY IMPAIRED—never/rarely made decisions
B5.	INDICATORS OF DELIRIUM—PERIODIC DISORDERED THINKING/AWARENESS	(Code for behavior in the last 7 days.) [Note: Accurate assessment requires conversations with staff and family who have direct knowledge of resident's behavior over this time]. 0. Behavior not present 1. Behavior present, not of recent onset 2. Behavior present, over last 7 days appears different from resident's usual functioning (e.g., new onset or worsening) a. EASILY DISTRACTED—(e.g., difficulty paying attention; gets sidetracked) b. PERIODS OF ALTERED PERCEPTION OR AWARENESS OF SURROUNDINGS—(e.g., moves lips or talks to someone not present; believes he/she is somewhere else; confuses night and day) c. EPISODES OF DISORGANIZED SPEECH—(e.g., speech is incoherent, nonsensical, irrelevant, or rambling from subject to subject; loses train of thought) d. PERIODS OF RESTLESSNESS—(e.g., fidgeting or picking at skin, clothing, napkins, etc; frequent position changes; repetitive physical movements or calling out) e. PERIODS OF LETHARGY—(e.g., sluggishness; staring into space; difficult to arouse; little body movement) f. MENTAL FUNCTION VARIES OVER THE COURSE OF THE DAY—(e.g., sometimes better, sometimes worse; behaviors sometimes present, sometimes not)
C4.	MAKING SELF UNDERSTOOD	(Expressing information content—however able) 0. UNDERSTOOD 1. USUALLY UNDERSTOOD—difficulty finding words or finishing thoughts 2. SOMETIMES UNDERSTOOD—ability is limited to making concrete requests 3. RARELY/NEVER UNDERSTOOD
C6.	ABILITY TO UNDERSTAND OTHERS	(Understanding verbal information content—however able) 0. UNDERSTANDS 1. USUALLY UNDERSTANDS—may miss some part/intent of message 2. SOMETIMES UNDERSTANDS—responds adequately to simple, direct communication 3. RARELY/NEVER UNDERSTANDS
E1.	INDICATORS OF DEPRESSION, 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"

E1.	INDICATORS OF DEPRESSION, ANXIETY, SAD MOOD (cont.)	VERBAL EXPRESSIONS OF DISTRESS 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 SAD, APATHETIC, ANXIOUS APPEARANCE l. Sad, pained, worried facial expressions—e.g., furrowed brows m. Crying, tearfulness n. Repetitive physical movements—e.g., pacing, hand wringing, restlessness, fidgeting, picking LOSS OF INTEREST o. Withdrawal from activities of interest—e.g., no interest in long standing activities or being with family/friends p. Reduced social interaction
E2.	MOOD PERSISTENCE	One or more indicators of depressed, sad or anxious mood were not easily altered by attempts to "cheer up", console, or reassure the resident over last 7 days 0. No mood indicators present, indicators easily altered 1. Indicators present, not easily altered 2. Indicators present, not easily altered	
E4.	BEHAVIORAL SYMPTOMS	(A) Behavioral symptom frequency in last 7 days 0. Behavior not exhibited in last 7 days 1. Behavior of this type occurred 1 to 3 days in last 7 days 2. Behavior of this type occurred 4 to 6 days, but less than daily 3. Behavior of this type occurred daily (B) Behavioral symptom alterability in last 7 days 0. Behavior not present OR behavior was easily altered 1. Behavior was not easily altered	(A) (B)
G1.	(A) ADL SELF-PERFORMANCE—(Code for resident's PERFORMANCE OVER ALL SHIFTS during last 7 days—Not including setup)	0. INDEPENDENT—No help or oversight —OR— Help/oversight provided only 1 or 2 times during last 7 days 1. SUPERVISION—Oversight, encouragement or cueing provided 3 or more times during last 7 days —OR— Supervision (3 or more times) plus physical assistance provided only 1 or 2 times during last 7 days 2. LIMITED ASSISTANCE—Resident highly involved in activity; received physical help in guided maneuvering of limbs or other nonweight bearing assistance 3 or more times —OR—More help provided only 1 or 2 times during last 7 days 3. EXTENSIVE ASSISTANCE—While resident performed part of activity, over last 7-day period, help of following type(s) provided 3 or more times: —Weight-bearing support — Full staff performance during part (but not all) of last 7 days 4. TOTAL DEPENDENCE—Full staff performance of activity during entire 7 days 8. ACTIVITY DID NOT OCCUR during entire 7 days	(A)
a.	BED MOBILITY	How resident moves to and from lying position, turns side to side, and positions body while in bed	
b.	TRANSFER	How resident moves between surfaces—to/from: bed, chair, wheelchair, standing position (EXCLUDE to/from bath/toilet)	
c.	WALK IN ROOM	How resident walks between locations in his/her room.	
d.	WALK IN CORRIDOR	How resident walks in corridor on unit.	
e.	LOCOMOTION ON UNIT	How resident moves between locations in his/her room and adjacent corridor on same floor. If in wheelchair, self-sufficiency once in chair	
f.	LOCOMOTION OFF UNIT	How resident moves to and returns from off unit locations (e.g., areas set aside for dining, activities, or treatments). If facility has only one floor, how resident moves to and from distant areas on the floor. If in wheelchair, self-sufficiency once in chair	
g.	DRESSING	How resident puts on, fastens, and takes off all items of street clothing, including donning/removing prosthesis	
h.	EATING	How resident eats and drinks (regardless of skill). Includes intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition).	

E. Older Adults and Arthritis

Relevant Questions:

Health-Related Quality of Life Questionnaire

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

See Next Page

PEDIATRIC SLEEP SURVEY

1. 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

11. 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 what you actually do, 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% 51-75%
26-50% 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	96
B. Epworth Sleepiness Scale.....	98
C. Exempla Healthcare Sleep Disorders Laboratory: Patient Education and Screening Questionnaire	100
D. Infant Screening Questionnaire.....	103
E. Leeds Sleep Evaluation Questionnaire.....	104
F. Maternal Child Supervision Questionnaire, 1961	106
G. Parental Interactive Bedtime Behavior Scale.....	109
H. Pediatric Sleep Questionnaire	112
I. Sinai Hospital Sleep Disorder Assessment Questionnaire	123
J. Sleep Apnea—The Phantom of the Night Questionnaire	126
K. Pittsburgh Sleep Quality Index	129
L. Stanford Sleepiness Scale.....	131
M. Functional Outcomes of Sleep Questionnaire	133

**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

See Next Page

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 indicates significant excessive daytime sleepiness.

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

See Next Page



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 ___

Patient Name _____

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? _____

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

A Brief Screening Questionnaire for Infant Sleep Problems: Validation and Findings for an Internet Sample -- Sadeh 113 (6): e570 -- Pediatrics

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 changes 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.

See Next Page

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 doctor's reports of the many questions or worries that mothers sometimes have about their new babies. Which one 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.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
BREATHING (uneven, hiccoughs, gags, chokes, gasps, grunts, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
HAIR (too much, too little, falling out, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eyes (shape, size, color, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Nose (size, shape, running, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
MOUTH-LIPS (size, shape, color sore, swallowing, thumb-sucking, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
SLEEPING (too much, not enough, not regular, restless)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
ACCIDENTS (while sleeping, eating, playing, bathing, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
HEAD (size, shape, soft spot, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
WEIGHT (not gaining, too fat, too thin, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
CRYING (too much, too little, strong, weak, turns color, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

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 little, 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) _____

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. 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.

The Parental Interactive Bedtime Behaviour Scale (PIBBS)

See Next Page

APPENDIX A 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	<input type="checkbox"/>				
2 Cuddling or rocking in arms	<input type="checkbox"/>				
3 Carrying around house in arms	<input type="checkbox"/>				
4 Walks in pram or buggy	<input type="checkbox"/>				
5 Car rides	<input type="checkbox"/>				
6 Music tape or musical toy	<input type="checkbox"/>				
7 Talking softly to child	<input type="checkbox"/>				
8 Singing a lullaby	<input type="checkbox"/>				
9 Reading a story to child	<input type="checkbox"/>				
10 Playing with child	<input type="checkbox"/>				
11 Offer a special toy/cloth	<input type="checkbox"/>				
12 Give a feed/drink	<input type="checkbox"/>				
13 Leave to cry	<input type="checkbox"/>				
14 Stand near cot without picking baby up	<input type="checkbox"/>				
15 Settle on sofa with parent	<input type="checkbox"/>				
16 Lie with child next to their cot	<input type="checkbox"/>				
17 Settle in parent's bed	<input type="checkbox"/>				
18 Give sleeping medication	<input type="checkbox"/>				
19 Alcohol	<input type="checkbox"/>				

Office Use only

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

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Inf. Child Dev. 11: 17–41 (2002)

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

See Next Page

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 <hr/> 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:

<u>Medicine</u>	<u>Size (mg) or amount per dose</u>	<u>Taken when?</u>
_____	_____	_____
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:

<u>Medicine</u>	<u>Size (mg) or amount per dose</u>	<u>Taken how often?</u>	<u>Dates Taken</u>
_____	_____	_____	_____
	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:

<u>Relative</u>	<u>Condition</u>
_____	_____
_____	_____
_____	_____

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	Appli es 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

See Next Page

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?

- 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

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.

SCORE

total

--

Sleep Questionnaire #2

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

See Next Page

Pittsburgh Sleep Quality Index (PSQI)

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.*

During the past month,

1. When have you usually gone to bed? _____
2. How long (in minutes) has it taken you to fall asleep each night? _____
3. When have you usually gotten up in the morning? _____
4. How many hours of actual sleep did you get that night? (This may be different than the number of hours you spend in bed) _____

5. During the past month, how often have you had trouble sleeping because you...	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)
a. Cannot get to sleep within 30 minutes				
b. Wake up in the middle of the night or early morning				
c. Have to get up to use the bathroom				
d. Cannot breathe comfortably				
e. Cough or snore loudly				
f. Feel too cold				
g. Feel too hot				
h. Have bad dreams				
i. Have pain				
j. Other reason(s), please describe, including how often you have had trouble sleeping because of this reason(s):				
6. During the past month, how often have you taken medicine (prescribed or "over the counter") to help you sleep?				
7. During the past month, how often have you had trouble staying awake while driving, eating meals, or engaging in social activity?				
8. During the past month, how much of a problem has it been for you to keep up enthusiasm to get things done?				
	Very good (0)	Fairly good (1)	Fairly bad (2)	Very bad (3)
9. During the past month, how would you rate your sleep quality overall?				

- Component 1** #9 Score C1 _____
- Component 2** #2 Score (≤ 15 min (0), 16-30 min (1), 31-60 min (2), >60 min (3))
+ #5a Score (if sum is equal 0=0; 1-2=1; 3-4=2; 5-6=3) C2 _____
- Component 3** #4 Score (>7 (0), 6-7(1), 5-6(2), <5 (3) C3 _____
- Component 4** (total # of hours asleep)/(total # of hours in bed) x 100 C4 _____
 $>85\%=0$, $75\%-84\%=1$, $65\%-74\%=2$, $<65\%=3$
- Component 5** # sum of scores 5b to 5j (0=0; 1-9=1; 10-18=2; 19-27=3) C5 _____
- Component 6** #6 Score C6 _____
- Component 7** #7 score + #8 score (0=0; 1-2=1; 3-4=2; 5-6=3) C7 _____

Add the seven component scores together _____ **Global PSQI Score** _____

Reprinted from *Journal of Psychiatric Research*, 28(2), Buysse, D.J., Reynolds III, C.F., Monk, T.H., Berman, S.R., & Kupfer, D.J. The Pittsburgh Sleep Quality Index: A New Instrument for Psychiatric Practice and Research, 193-213, Copyright 1989, with permission from Elsevier Science.

L. Stanford Sleepiness Scale

See Next Page

Stanford Sleepiness Scale:

Alertness peaks: 9 AM, 9 PM

Alertness nadir: 3 PM

If you score below 3, serious sleep debt

Feeling active, vital, alert, or wide awake	1
Function= high levels,not peak; able to concentrate	2
Awake, but relaxed; responsive but not fully alert	3
Somewhat foggy, let down	4
Foggy; harder to be 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

See Next Page

FOSQ Test

Note: In this questionnaire, when the words “sleep” 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 nap. These words do not refer to the tired or fatigued feeling you may have after you exercised.

FOSQ questions are answered using numbers from 0 to 4 (see answer key below):

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 things you do because you are sleepy or tired?

0 1 2 3 4

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

0 1 2 3 4

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

0 1 2 3 4

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

0 1 2 3 4

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 sleep or tired?

0 1 2 3 4

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

0 1 2 3 4

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

0 1 2 3 4

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

0 1 2 3 4

Q9) Do you have difficulty take 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?

0 1 2 3 4

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

0 1 2 3 4

Q11) Do you have difficulty maintaining a telephone conversation because you become sleepy or tired?

0 1 2 3 4

Q12) Do you have difficulty visiting with you family or friends in your home

because you become sleepy or tired?

0 1 2 3 4

Q13) Do you have difficulty visiting with your family or friends in their homes because you become sleepy or tired?

0 1 2 3 4

Q14) Do you have difficulty doing things for your family or friends because you become sleepy or tired?

0 1 2 3 4

(For Question 15 answer using only 1,2,3,or 4.)

Q15) Has your relationship with family, friends or work colleagues been affected because you are sleepy or tired?

1 2 3 4

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

0 1 2 3 4

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

0 1 2 3 4

Q18) Do you have difficulty enjoying the theater or a lecture because you become sleepy or tired?

0 1 2 3 4

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

0 1 2 3 4

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

0 1 2 3 4

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

0 1 2 3 4

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

0 1 2 3 4

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

0 1 2 3 4

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

0 1 2 3 4

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

0 1 2 3 4

Q26) How would you rate yourself in your general level of activity?

1= Very low; 2= Low; 3= Medium; 4= High

1 2 3 4

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

0 1 2 3 4

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

0 1 2 3 4

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

0 1 2 3 4

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

0 1 2 3 4

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/1999PRAMSurv.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/ftplib/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_data/surveys/nhis/type_txt/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/slait/nsch.htm>

Questionnaire: http://www.cdc.gov/nchs/data/slait/NSCH_Questionnaire.pdf

Page 39 of 65

I-N. National Survey of Early Childhood Health

Homepage: <http://www.cdc.gov/nchs/about/major/slait/nsech.htm>

Questionnaire: http://www.cdc.gov/nchs/data/slait/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.healthresources.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