Appendices

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July 2006
Quick Links to Population-Based Studies

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

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Appendix I.
Relevant Questions From National Studies
# Table of Contents

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

Relevant Questions:

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

Section 4: Diary

<table>
<thead>
<tr>
<th>ACTIVITY</th>
<th>Universe: All</th>
</tr>
</thead>
<tbody>
<tr>
<td>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.</td>
<td></td>
</tr>
<tr>
<td>1. Sleeping 30. Don't know/ Can't remember</td>
<td></td>
</tr>
<tr>
<td>2. Grooming (self) 31. Refusal/ None of your business</td>
<td></td>
</tr>
<tr>
<td>3. Watching TV</td>
<td></td>
</tr>
<tr>
<td>4. Working at main job</td>
<td></td>
</tr>
<tr>
<td>5. Working at other job</td>
<td></td>
</tr>
<tr>
<td>6. Preparing meals or snacks</td>
<td></td>
</tr>
<tr>
<td>7. Eating and drinking</td>
<td></td>
</tr>
<tr>
<td>8. Cleaning kitchen</td>
<td></td>
</tr>
<tr>
<td>9. Laundry</td>
<td></td>
</tr>
<tr>
<td>10. Grocery shopping</td>
<td></td>
</tr>
<tr>
<td>11. Attending religious service</td>
<td></td>
</tr>
<tr>
<td>12. Paying household bills</td>
<td></td>
</tr>
<tr>
<td>13. Caring for animals and pets [Go to TIME]</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>TIME</th>
<th>Universe: ACTIVITY = valid response</th>
</tr>
</thead>
<tbody>
<tr>
<td>How long did you spend [ACTIVITY]?</td>
<td></td>
</tr>
<tr>
<td>1. Enter duration (hours, minutes). [Go to HOURDUR]</td>
<td></td>
</tr>
<tr>
<td>2. Enter stop time. [Go to STOPTIME]</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>HOURDUR</th>
<th>Universe: Activity = valid response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enter Hours [Go to MINDUR]</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>MINDUR</th>
<th>Universe: All</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enter Minutes [Go to STOPTIME]</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>STOPTIME</th>
<th>Universe: All</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enter AM or PM</td>
<td></td>
</tr>
</tbody>
</table>
Appendix I

B. Behavioral Risk Factor Surveillance System State Questionnaire

Relevant Questions:

Module 7: Quality of Life

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

   a. Number of days .................................................. ---

   b. None ............................................................... 8 8

      Don’t know/Not sure .............................................. 7 7

      Refused ............................................................. 9 9
Behavioral Risk Factor Questionnaire, 2001

Module 3: Quality of Life and Care Giving

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

<table>
<thead>
<tr>
<th>Number of days</th>
<th>8</th>
<th>8</th>
<th>None</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>7</td>
<td>7</td>
<td>Don't know/Not sure</td>
</tr>
<tr>
<td></td>
<td>9</td>
<td>9</td>
<td>Refused</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Would you say</th>
<th>8</th>
<th>None</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
<td>One or two</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>Three to five</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>Six to ten</td>
</tr>
<tr>
<td>or</td>
<td>4</td>
<td>More than ten</td>
</tr>
</tbody>
</table>

Do not read these responses

<table>
<thead>
<tr>
<th>Do not read these responses</th>
<th>7</th>
<th>Don't know/Not sure</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>9</td>
<td>Refused</td>
</tr>
</tbody>
</table>

Behavioral Risk Factor Questionnaire, 2002

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

Please Read

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

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

Relevant Questions:

45. How do you put your new baby down to sleep most of the time? Check one answer.
   □ On his or her side
   □ On his or her back
   □ On his or her stomach

46. How many times has your baby been to a doctor or nurse for routine well-baby care?
   Don’t count the times you took your baby for care when he or she was sick. It may help to use the calendar.
   ___ Times
   □ My baby hasn’t been for routine well-baby care —> Go to Question 48

47. When your baby goes for routine well-baby care, where do you take him or her?
   Check all the places that you use.
   □ Hospital clinic
   □ Health department clinic
   □ Private doctor’s office
   □ Other —> Please tell us:

51. What is today’s date? ___/___/___
    month day year

52. What is your date of birth? ___/___/___
    month day year

D. Fatality Analysis Reporting System

Relevant Question:

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

E. Framingham Heart Study

Relevant Questions:

Relevant information was included in the study’s data collection forms. Related sections are included below.
Cohort Data Collection Forms:

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

<table>
<thead>
<tr>
<th>Details for &quot;Serious&quot; Cerebrovascular Event in Interim</th>
</tr>
</thead>
<tbody>
<tr>
<td>Examiner’s opinion that &quot;serious&quot; or &quot;significant&quot; cerebrovascular event took place in interim (0=No, 1=Yes, 2=Maybe, 9=Unknown)</td>
</tr>
<tr>
<td>Date (mo/yr, 99/99=Unknown)</td>
</tr>
<tr>
<td>Observed by ___________________________</td>
</tr>
<tr>
<td>Onset time (1=Active, 2=During sleep, 3=While arising, 9=Unknown)</td>
</tr>
<tr>
<td>Exact/approximate time (use 24-hour military time, 99.99=Unknown)</td>
</tr>
<tr>
<td>Duration (use format days/hours/mins, 99.99/99/99=Unknown)</td>
</tr>
<tr>
<td>Hospitalized or saw M.D. (0=No, 1=Hospital, 2=Saw M.D., 9=Unknown)</td>
</tr>
<tr>
<td>Number of days stayed at</td>
</tr>
</tbody>
</table>

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

Offspring Data Collection Forms:

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

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

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

<table>
<thead>
<tr>
<th>Questions to be answered</th>
<th>Rarely or none of the time (less than 1 day)</th>
<th>Some or a little of the time (1-2 days)</th>
<th>Occasionally or moderate amount of time (3-4 days)</th>
<th>Most or all of the time (5-7 days)</th>
<th>Unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td>11. My sleep was restless.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>9</td>
</tr>
</tbody>
</table>
F. Global School-Based Survey 2004 Core Questionnaire

Relevant Question:

*Mental Health Section:*

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

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

G. National Asthma Survey, 2003

Relevant Question:

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

ASLEEP30 (4.3)

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

--- DAYS/NIGHTS

[RANGE CHECK: (00-30, 96, 97)]

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


Relevant Questions:

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

________________________ # HOURS

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

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

*

Appendix I

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

*64447*
*5 5*
*94448* GO TO
*D10. Have you ever had 2 weeks or more when nearly every night it took you at least 2 hours to fall asleep?

* (97)

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

*64447*
*5 5* GO TO
*94448* D13

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

*64447*
*5 5*
*94448*

* (98)

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

*64447*
*5 5*
*94448*

* (98)

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

*64447*
*5 5*
*94448*

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

*X3d. Did his sleep habits change?

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

*X8a. ... have difficulty falling asleep?

X13. Did he ever abuse prescription drugs such as valium, sleeping pills, or diet pills?

64444447 ()))))))) ())))))))))))))))))
51. YB5 *5. NO* *8. DON'T KNOW*
94444448 ()))))))- ())))))))))))))-

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

*X29d. Did her sleep habits change?

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

*X34a. ... have difficulty falling asleep?
Appendix I

I. National Health Interview Survey, 2002

Relevant Questions:

X39. Did she ever abuse prescription drugs such as valium, sleeping pills, or diet pills?

64444447 +)))))) +)))))))))))))))
51. YB85 *5. NO* +8. DON’T KNOW*
94444448 .))))))-.))))))))))))-

REACTIONS WHEN YOU WERE WORRIED OR ANXIOUS

16. Trouble falling or staying asleep

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

7. Took at least 2 hours to fall asleep

YOU HAD A PERIOD WHEN YOU(R) ...

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

I. National Health Interview Survey, 2002

Relevant Questions:

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

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

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

Section: Conditions

<table>
<thead>
<tr>
<th>ACN.125.050</th>
<th>DURING THE PAST 12 MONTHS have you …</th>
</tr>
</thead>
<tbody>
<tr>
<td>&gt;CSYR&lt;</td>
<td>(1) Yes</td>
</tr>
<tr>
<td></td>
<td>(2) No</td>
</tr>
<tr>
<td>(7) Refused</td>
<td>(9) Don’t know</td>
</tr>
</tbody>
</table>

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

Module: Child Core Questionnaire

Section: Mental Health

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

FR: SHOW FLASHCARD C3

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

HE:

>CMHAGM12< ... has been uncooperative?
>CMHAGM13< ... has trouble getting to sleep?
>CMHAGM14< ... has speech problems?
>CMHAGM15< ... has been unhappy, sad, or depressed?
2002 Variable Supplement: Alternative Medicine

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

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

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

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

>ACUCON01<
>ACUCON02<
>ACUCON03<
>ACUCON04<
>ACUCON05<
>ACUCON06<
>ACUCON07<
>ACUCON08<
>ACUCON09<
>ACUCON10<
>ACUCON11<
>ACUCON12<
>ACUCON13<
>ACUCON14<
>ACUCON15<
>ACUCON16<
>ACUCON17<
>ACUCON18<
>ACUCON19<
>ACUCON20<
>ACUCON21<
>ACUCON22<
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>ACUCON24<
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>ACUCON26<
>ACUCON27<
>ACUCON28<
>ACUCON29<
>ACUCON30<
>ACUCON31<
>ACUCON32<
>ACUCON33<
>ACUCON34<
>ACUCON35<
>ACUCON36<
>ACUCON37<
>ACUCON38<
Relevant Questions:

Codebook for Data Release (2001-2002)
NHANES Composite International Diagnostic Interview-Major Depression Module (CIQDEP_B)
Person level data -- use CIDI Weights for analysis
February 2005
CIQD018
B(20 Yrs. to 39 Yrs.)
When irritable, did you lack energy?
English Text: For the next questions, please think of the two weeks during the past 12 months when you were irritable and had the largest number of these other problems. During that two-week period, did you lack energy or feel tired all the time nearly every day, even when you had not been working very hard? English Instructions: (IF R SAYS THERE WAS NO SINGLE TWO-WEEK PERIOD THAT STANDS OUT, SAY: Then think of the most recent two weeks of this sort.) (Collection name = E2_1C_1)

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

CIQD026
B(20 Yrs. to 39 Yrs.)
Frequency trouble sleeping
English Text: Did this happen every night, nearly every night, or less often during those two weeks? English Instructions: (Collection name = E8_1)
Codes:
Skip To Values:
1= Every night
2= Nearly every night
3= Less often
7= Refuse
9= Don't know

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

CIQD028
B(20 Yrs. to 39 Yrs.)
Did you sleep too much?
English Text: Did you sleep too much almost every day?
K. National Household Survey on Drug Abuse

Relevant Questions:

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

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

1 Yes
2 No
DK REF

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

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

1 Yes
2 No
DK REF

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

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

1 Yes
2 No
DK REF
**Appendix I**

**K. National Household Survey on Drug Abuse**

**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. 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
Appendix I

K. National Household Survey on Drug Abuse

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

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

1 Yes
2 No
DK/REF

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

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

1 Yes
2 No
DK/REF

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

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

1 Yes
2 No
DK/REF

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

1 Yes
2 No
DK/REF

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

1 Yes
2 No
DK/REF
MASLEEP  
[IF MAFEEL=1] During the time when you were extremely excited or hyper, did you find that you could hardly sleep at all but still you didn't feel tired?

1  Yes  
2  No  
DK/REF

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

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

1  Yes  
2  No  
DK/REF

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

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

1  YES  
2  NO  
DK/REF

L. National Sleep Foundation, Sleep in America Poll

Relevant Questions:

The complete questionnaire is included.

National Sleep Foundation  
2005 Sleep in America Poll  
Screening Questionnaire

Respondent Name: ______________________________

Telephone Number: ______________________________

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

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.)*

<table>
<thead>
<tr>
<th>Time</th>
<th>Option</th>
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<tbody>
<tr>
<td>00:00 AM (Midnight)</td>
<td>01</td>
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<td>10:00 PM – 11:00 PM</td>
<td>41</td>
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<tr>
<td>11:00 PM – 12:00 AM</td>
<td>42</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Time</th>
<th>Option</th>
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<tbody>
<tr>
<td>00:00 AM (Midnight)</td>
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<td>02:00 AM – 03:59 AM</td>
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<td>11:00 PM – 12:00 AM</td>
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</tbody>
</table>

Refused: 98
Don't know: 99
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.)

<table>
<thead>
<tr>
<th>Time</th>
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</thead>
<tbody>
<tr>
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<td>14 7:45 AM – 7:59 AM</td>
<td>98 Refused</td>
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<td>15 8:00 AM – 8:14 AM</td>
<td>99 Don’t know</td>
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<td>16 8:15 AM – 8:29 AM</td>
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<tr>
<td>98 Refused</td>
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<tr>
<td>99 Don’t know</td>
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</tr>
</tbody>
</table>

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.)

<table>
<thead>
<tr>
<th>Time</th>
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<tbody>
<tr>
<td>01 12:00 AM (Midnight)</td>
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<td>10 9:00 PM – 9:14 PM</td>
<td>98 Refused</td>
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<tr>
<td>11 9:15 PM – 9:29 PM</td>
<td>99 Don’t know</td>
</tr>
<tr>
<td>12 9:30 PM – 9:44 PM</td>
<td></td>
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</tbody>
</table>
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?

<table>
<thead>
<tr>
<th>Activity</th>
<th>Every night or almost every night</th>
<th>A few nights a week</th>
<th>A few nights a month</th>
<th>Rarely</th>
<th>Never</th>
<th>Refused</th>
<th>Don’t know</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Did work relating to your job</td>
<td>05</td>
<td>04</td>
<td>03</td>
<td>02</td>
<td>01</td>
<td>98</td>
<td>99</td>
</tr>
<tr>
<td>b. Watched TV</td>
<td>05</td>
<td>04</td>
<td>03</td>
<td>02</td>
<td>01</td>
<td>98</td>
<td>99</td>
</tr>
<tr>
<td>c. Listened to the radio or music</td>
<td>05</td>
<td>04</td>
<td>03</td>
<td>02</td>
<td>01</td>
<td>98</td>
<td>99</td>
</tr>
<tr>
<td>d. Were on the Internet</td>
<td>05</td>
<td>04</td>
<td>03</td>
<td>02</td>
<td>01</td>
<td>98</td>
<td>99</td>
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<tr>
<td>e. Read</td>
<td>05</td>
<td>04</td>
<td>03</td>
<td>02</td>
<td>01</td>
<td>98</td>
<td>99</td>
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<tr>
<td>f. Had sex</td>
<td>05</td>
<td>04</td>
<td>03</td>
<td>02</td>
<td>01</td>
<td>98</td>
<td>99</td>
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<tr>
<td>g. Exercised</td>
<td>05</td>
<td>04</td>
<td>03</td>
<td>02</td>
<td>01</td>
<td>98</td>
<td>99</td>
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<tr>
<td>h. Spent time with family/friends</td>
<td>05</td>
<td>04</td>
<td>03</td>
<td>02</td>
<td>01</td>
<td>98</td>
<td>99</td>
</tr>
<tr>
<td>i. Drank an alcoholic beverage</td>
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<td>04</td>
<td>03</td>
<td>02</td>
<td>01</td>
<td>98</td>
<td>99</td>
</tr>
<tr>
<td>j. Took a hot bath/shower</td>
<td>05</td>
<td>04</td>
<td>03</td>
<td>02</td>
<td>01</td>
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<td>99</td>
</tr>
</tbody>
</table>
6c. Do you have any of the following in your bedroom? (READ LIST. RANDOMIZE.)

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Refused</th>
<th>Don’t know</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Television</td>
<td>01</td>
<td>02</td>
<td>98</td>
<td>99</td>
</tr>
<tr>
<td>b. Computer</td>
<td>01</td>
<td>02</td>
<td>98</td>
<td>99</td>
</tr>
<tr>
<td>c. Telephone</td>
<td>01</td>
<td>02</td>
<td>98</td>
<td>99</td>
</tr>
<tr>
<td>d. Radio/Stereo/DVD</td>
<td>01</td>
<td>02</td>
<td>98</td>
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</tbody>
</table>

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?

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

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?

<table>
<thead>
<tr>
<th>Question</th>
<th>Every night or almost every night</th>
<th>A few nights a week</th>
<th>A few nights a month</th>
<th>Rarely</th>
<th>Never</th>
<th>Refused</th>
<th>Don’t know</th>
</tr>
</thead>
<tbody>
<tr>
<td>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.</td>
<td>05</td>
<td>04</td>
<td>03</td>
<td>02</td>
<td>01</td>
<td>98</td>
<td>99</td>
</tr>
<tr>
<td>b. Move your body frequently or have twitches often during the night.</td>
<td>05</td>
<td>04</td>
<td>03</td>
<td>02</td>
<td>01</td>
<td>98</td>
<td>99</td>
</tr>
</tbody>
</table>

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.)

<table>
<thead>
<tr>
<th>Number</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>Worse at night</td>
</tr>
<tr>
<td>02</td>
<td>About the same as</td>
</tr>
<tr>
<td>03</td>
<td>Better at night</td>
</tr>
<tr>
<td>98</td>
<td>Refused</td>
</tr>
<tr>
<td>99</td>
<td>Don’t know</td>
</tr>
</tbody>
</table>
### ASK EVERYONE

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

<table>
<thead>
<tr>
<th></th>
<th></th>
<th>→ CONTINUE</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>02</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>98</td>
<td>Refused</td>
<td></td>
</tr>
<tr>
<td>99</td>
<td>Don’t know</td>
<td></td>
</tr>
</tbody>
</table>

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

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

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>04</td>
<td>Slightly louder than breathing,</td>
<td></td>
</tr>
<tr>
<td>03</td>
<td>As loud as talking,</td>
<td></td>
</tr>
<tr>
<td>02</td>
<td>Louder than talking, or</td>
<td></td>
</tr>
<tr>
<td>01</td>
<td>Very loud and can be heard in adjacent rooms?</td>
<td></td>
</tr>
<tr>
<td>98</td>
<td>DO NOT READ: Refused</td>
<td></td>
</tr>
<tr>
<td>99</td>
<td>DO NOT READ: Don’t know</td>
<td></td>
</tr>
</tbody>
</table>

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

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>05</td>
<td>Every night or almost every night,</td>
<td></td>
</tr>
<tr>
<td>04</td>
<td>3 to 4 nights a week,</td>
<td></td>
</tr>
<tr>
<td>03</td>
<td>1 to 2 nights a week, or</td>
<td></td>
</tr>
<tr>
<td>02</td>
<td>1 to 2 nights a month?</td>
<td></td>
</tr>
<tr>
<td>01</td>
<td>DO NOT READ: Never/Less often</td>
<td></td>
</tr>
<tr>
<td>98</td>
<td>DO NOT READ: Refused</td>
<td></td>
</tr>
<tr>
<td>99</td>
<td>DO NOT READ: Don’t know</td>
<td></td>
</tr>
</tbody>
</table>

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

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>02</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>98</td>
<td>Refused</td>
<td></td>
</tr>
<tr>
<td>99</td>
<td>Don’t know</td>
<td></td>
</tr>
</tbody>
</table>
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.)

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Refused</th>
<th>Don’t know</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Sleep in a separate bed, bedroom or on the couch</td>
<td>01</td>
<td>02</td>
<td>98</td>
</tr>
<tr>
<td>b. Alter your sleep schedules</td>
<td>01</td>
<td>02</td>
<td>98</td>
</tr>
<tr>
<td>c. Sleep with earplugs or an eye mask</td>
<td>01</td>
<td>02</td>
<td>98</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Not sure</th>
<th>Refused</th>
<th>Don’t know</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. He or she have difficulty falling asleep</td>
<td>01</td>
<td>02</td>
<td>03</td>
<td>98</td>
</tr>
<tr>
<td>b. He or she wake a lot during the night</td>
<td>01</td>
<td>02</td>
<td>03</td>
<td>98</td>
</tr>
<tr>
<td>c. He or she wake up too early and could not get back to sleep</td>
<td>01</td>
<td>02</td>
<td>03</td>
<td>98</td>
</tr>
<tr>
<td>d. He or she wake up feeling unrefreshed</td>
<td>01</td>
<td>02</td>
<td>03</td>
<td>98</td>
</tr>
</tbody>
</table>
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.)

<table>
<thead>
<tr>
<th>Problem</th>
<th>Yes</th>
<th>No</th>
<th>Not sure</th>
<th>Refused</th>
<th>Don’t know</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Snore</td>
<td>01</td>
<td>02</td>
<td>03</td>
<td>98</td>
<td>99</td>
</tr>
<tr>
<td>b. Have pauses in his or her breathing during sleep</td>
<td>01</td>
<td>02</td>
<td>03</td>
<td>98</td>
<td>99</td>
</tr>
<tr>
<td>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</td>
<td>01</td>
<td>02</td>
<td>03</td>
<td>98</td>
<td>99</td>
</tr>
<tr>
<td>d. Move his or her body frequently or have twitches often during the night</td>
<td>01</td>
<td>02</td>
<td>03</td>
<td>98</td>
<td>99</td>
</tr>
</tbody>
</table>

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?

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

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.)

<table>
<thead>
<tr>
<th>Statement</th>
<th>Completely Agree</th>
<th>Mostly Agree</th>
<th>Mostly Disagree</th>
<th>Completely Disagree</th>
<th>Refused</th>
<th>Don’t know</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. You can learn to function well over time with one or two fewer hours of sleep than you need.</td>
<td>04</td>
<td>03</td>
<td>02</td>
<td>01</td>
<td>98</td>
<td>99</td>
</tr>
<tr>
<td>b. Doctors should discuss sleep issues with their patients.</td>
<td>04</td>
<td>03</td>
<td>02</td>
<td>01</td>
<td>98</td>
<td>99</td>
</tr>
<tr>
<td>c. Sleep problems are associated with being overweight or obese.</td>
<td>04</td>
<td>03</td>
<td>02</td>
<td>01</td>
<td>98</td>
<td>99</td>
</tr>
<tr>
<td>d. Insufficient or poor sleep is associated with health problems.</td>
<td>04</td>
<td>03</td>
<td>02</td>
<td>01</td>
<td>98</td>
<td>99</td>
</tr>
</tbody>
</table>
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
Appendix I  L. National Sleep Foundation, Sleep in America Poll

**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** ➔ SKIP TO Q53

98  Refused
99  Don’t know

**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.)

<table>
<thead>
<tr>
<th>Condition</th>
<th>Yes</th>
<th>No</th>
<th>Refused</th>
<th>Don’t know</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Heart disease</td>
<td>01</td>
<td>02</td>
<td>98</td>
<td>99</td>
</tr>
<tr>
<td>b. Arthritis</td>
<td>01</td>
<td>02</td>
<td>98</td>
<td>99</td>
</tr>
<tr>
<td>c. Diabetes</td>
<td>01</td>
<td>02</td>
<td>98</td>
<td>99</td>
</tr>
<tr>
<td>d. Heartburn or GERD</td>
<td>01</td>
<td>02</td>
<td>98</td>
<td>99</td>
</tr>
<tr>
<td>e. Depression</td>
<td>01</td>
<td>02</td>
<td>98</td>
<td>99</td>
</tr>
<tr>
<td>f. Anxiety disorder such as panic disorder or post dramatic stress disorder</td>
<td>01</td>
<td>02</td>
<td>98</td>
<td>99</td>
</tr>
<tr>
<td>g. Lung disease</td>
<td>01</td>
<td>02</td>
<td>98</td>
<td>99</td>
</tr>
<tr>
<td>h. High blood pressure</td>
<td>01</td>
<td>02</td>
<td>98</td>
<td>99</td>
</tr>
</tbody>
</table>

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, ➔ CONTINUE
02 Working full-time, ➔ SKIP TO D1
03 Working part-time,
04 A student,
05 A homemaker,
06 Unemployed,
07 Retired,
08 Disabled, or a
09 Volunteer?
95 DO NOT READ: Other (SPECIFY): _______________________
98 DO NOT READ: Refused
99 DO NOT READ: Don’t know
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

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
Appendix I

M. National Survey of Children’s Health, 2003

Relevant Question:

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

____ NUMBER OF DAYS  [RANGE CHECK: 00-07]

(96) DON'T KNOW
(97) REFUSED

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

N. National Survey of Early Childhood Health

Relevant Questions:

Section 3: Interactions with Health Care Providers

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

<table>
<thead>
<tr>
<th>YES</th>
<th>1</th>
<th>SKIP TO A3Q04</th>
</tr>
</thead>
<tbody>
<tr>
<td>NO</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>DK</td>
<td>6</td>
<td>SKIP TO A3Q04</td>
</tr>
<tr>
<td>REFUSED</td>
<td>7</td>
<td>SKIP TO A3Q04</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>YES</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>NO</td>
<td>2</td>
</tr>
<tr>
<td>DK</td>
<td>6</td>
</tr>
<tr>
<td>REFUSED</td>
<td>7</td>
</tr>
</tbody>
</table>

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?

<table>
<thead>
<tr>
<th>YES</th>
<th>1</th>
<th>SKIP TO A3Q15</th>
</tr>
</thead>
<tbody>
<tr>
<td>NO</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>DK</td>
<td>6</td>
<td>SKIP TO A3Q15</td>
</tr>
<tr>
<td>REFUSED</td>
<td>7</td>
<td>SKIP TO A3Q15</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>YES</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>NO</td>
<td>2</td>
</tr>
<tr>
<td>CHILD DOES NOT USE A BOTTLE</td>
<td>3</td>
</tr>
<tr>
<td>DK</td>
<td>6</td>
</tr>
<tr>
<td>REFUSED</td>
<td>7</td>
</tr>
</tbody>
</table>
O. Nurses’ Health Study

Relevant Questions:

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

2001
Question 12
Question 13
Question 15
Question 42

2002
Question 2
Question 3

2004
Question 55

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

Relevant Questions:

Exception 1:

```markdown
##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:

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

Part D2:

c) When you need more time, do you tend to cut back on your sleep?

<1> Yes
<3> No
<x> Don’t know
<r> Refused
Part F:

F49  Why are you dissatisfied? [Mark all that apply]

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

Part L:

L25  Do you regularly have trouble going to sleep or staying asleep?

<1>  Yes
<3>  No
<r>  Refused


Relevant Questions:

“Time Use,” Round 3:

YTIM-300D

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

Lead-In: YTIM-300C [Def]

YTIM-500

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

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

Lead-In: YTIM-300D [Def]

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?

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

**Source Form: 37**  
**Usage Notes: none**

#### F37 Did you nap during the day

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

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

**Source Form: 37**  
**Usage Notes: none**

#### F37 Did you snore

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

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

**Source Form: 37**  
**Usage Notes: none**
### 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?

<table>
<thead>
<tr>
<th>Values</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 No, not in past 4 weeks</td>
<td>35,194</td>
<td>21.6%</td>
</tr>
<tr>
<td>2 Yes, less than once a week</td>
<td>27,334</td>
<td>16.9%</td>
</tr>
<tr>
<td>3 Yes 1 or 2 times a week</td>
<td>34,153</td>
<td>21.1%</td>
</tr>
<tr>
<td>4 Yes, 3 or 4 times a week</td>
<td>28,713</td>
<td>17.7%</td>
</tr>
<tr>
<td>5 Yes, 5 or more times a week</td>
<td>34,961</td>
<td>21.6%</td>
</tr>
<tr>
<td>Missing</td>
<td>1,442</td>
<td>0.9%</td>
</tr>
</tbody>
</table>

**Source Form:** 37  
**Usage Notes:** none

### F37 How many hours of sleep

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

<table>
<thead>
<tr>
<th>Values</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 5 or less hours</td>
<td>13,094</td>
<td>8.4%</td>
</tr>
<tr>
<td>2 6 hours</td>
<td>44,364</td>
<td>27.4%</td>
</tr>
<tr>
<td>3 7 hours</td>
<td>60,241</td>
<td>37.2%</td>
</tr>
<tr>
<td>4 8 hours</td>
<td>35,728</td>
<td>22.1%</td>
</tr>
<tr>
<td>5 9 hours</td>
<td>6,205</td>
<td>3.8%</td>
</tr>
<tr>
<td>6 10 or more hours</td>
<td>839</td>
<td>0.5%</td>
</tr>
<tr>
<td>Missing</td>
<td>828</td>
<td>0.5%</td>
</tr>
</tbody>
</table>

**Source Form:** 37  
**Usage Notes:** none

### F37 Typical nights sleep

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

<table>
<thead>
<tr>
<th>Values</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Very restless</td>
<td>3,029</td>
<td>2.2%</td>
</tr>
<tr>
<td>2 Restless</td>
<td>22,732</td>
<td>14.0%</td>
</tr>
<tr>
<td>3 Average quality</td>
<td>67,627</td>
<td>41.8%</td>
</tr>
<tr>
<td>4 Sound or restful</td>
<td>46,161</td>
<td>28.5%</td>
</tr>
<tr>
<td>5 Very sound or restful</td>
<td>20,738</td>
<td>12.8%</td>
</tr>
<tr>
<td>Missing</td>
<td>912</td>
<td>0.6%</td>
</tr>
</tbody>
</table>

**Source Form:** 37  
**Usage Notes:** none
### 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

<table>
<thead>
<tr>
<th>Values</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Rarely or none of the time</td>
<td>69,961</td>
</tr>
<tr>
<td>1</td>
<td>Some or a little of the time</td>
<td>58,053</td>
</tr>
<tr>
<td>2</td>
<td>Occasionally or a moderate amount</td>
<td>21,566</td>
</tr>
<tr>
<td>3</td>
<td>Most or all of the time</td>
<td>10,729</td>
</tr>
<tr>
<td>Missing</td>
<td>1,488</td>
<td>0.9%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>161,797</strong></td>
<td></td>
</tr>
</tbody>
</table>

Source Form: 37

Usage Notes: none

---

### F37 fall asleep during quiet activity

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

<table>
<thead>
<tr>
<th>Values</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>No, not in past 4 weeks</td>
<td>39,841</td>
</tr>
<tr>
<td>2</td>
<td>Yes, less than once a week</td>
<td>36,279</td>
</tr>
<tr>
<td>3</td>
<td>Yes 1 or 2 times a week</td>
<td>41,822</td>
</tr>
<tr>
<td>4</td>
<td>Yes, 3 or 4 times a week</td>
<td>26,125</td>
</tr>
<tr>
<td>5</td>
<td>Yes, 5 or more times a week</td>
<td>16,554</td>
</tr>
<tr>
<td>Missing</td>
<td>1,176</td>
<td>0.7%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>161,797</strong></td>
<td></td>
</tr>
</tbody>
</table>

Source Form: 37

Usage Notes: none

---

### F37 take medication for sleep

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

<table>
<thead>
<tr>
<th>Values</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>No, not in past 4 weeks</td>
<td>122,162</td>
</tr>
<tr>
<td>2</td>
<td>Yes, less than once a week</td>
<td>14,867</td>
</tr>
<tr>
<td>3</td>
<td>Yes 1 or 2 times a week</td>
<td>6,969</td>
</tr>
<tr>
<td>4</td>
<td>Yes, 3 or 4 times a week</td>
<td>4,565</td>
</tr>
<tr>
<td>5</td>
<td>Yes, 5 or more times a week</td>
<td>10,131</td>
</tr>
<tr>
<td>Missing</td>
<td>1,103</td>
<td>0.7%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>161,797</strong></td>
<td></td>
</tr>
</tbody>
</table>

Source Form: 37

Usage Notes: none
### 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?

<table>
<thead>
<tr>
<th>Values</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>No, not in past 4 weeks</td>
<td>77,725</td>
<td>48.0%</td>
</tr>
<tr>
<td>Yes, less than once a week</td>
<td>32,296</td>
<td>20.0%</td>
</tr>
<tr>
<td>Yes 1 or 2 times a week</td>
<td>26,664</td>
<td>16.6%</td>
</tr>
<tr>
<td>Yes, 3 or 4 times a week</td>
<td>14,103</td>
<td>8.8%</td>
</tr>
<tr>
<td>Yes, 5 or more times a week</td>
<td>9,358</td>
<td>5.8%</td>
</tr>
<tr>
<td>Missing</td>
<td>1,391</td>
<td>0.9%</td>
</tr>
<tr>
<td>Total</td>
<td>161,797</td>
<td></td>
</tr>
</tbody>
</table>

Source Form: 37
Usage Notes: none

### F37 wake up earlier than planned

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

<table>
<thead>
<tr>
<th>Values</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>No, not in past 4 weeks</td>
<td>66,246</td>
<td>40.9%</td>
</tr>
<tr>
<td>Yes, less than once a week</td>
<td>34,561</td>
<td>21.4%</td>
</tr>
<tr>
<td>Yes 1 or 2 times a week</td>
<td>30,607</td>
<td>18.9%</td>
</tr>
<tr>
<td>Yes, 3 or 4 times a week</td>
<td>17,388</td>
<td>10.7%</td>
</tr>
<tr>
<td>Yes, 5 or more times a week</td>
<td>11,638</td>
<td>7.2%</td>
</tr>
<tr>
<td>Missing</td>
<td>1,357</td>
<td>0.8%</td>
</tr>
<tr>
<td>Total</td>
<td>161,797</td>
<td></td>
</tr>
</tbody>
</table>

Source Form: 37
Usage Notes: none

### F42 Number of hours spent sleeping

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

<table>
<thead>
<tr>
<th>Values</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 4 hours</td>
<td>5,970</td>
<td>6.4%</td>
</tr>
<tr>
<td>4-5 hours</td>
<td>2,905</td>
<td>3.1%</td>
</tr>
<tr>
<td>6-7 hours</td>
<td>25,445</td>
<td>27.2%</td>
</tr>
<tr>
<td>8-9 hours</td>
<td>42,332</td>
<td>45.2%</td>
</tr>
<tr>
<td>10-11 hours</td>
<td>12,733</td>
<td>13.6%</td>
</tr>
<tr>
<td>12-13 hours</td>
<td>2,739</td>
<td>2.9%</td>
</tr>
<tr>
<td>14-15 hours</td>
<td>585</td>
<td>0.6%</td>
</tr>
<tr>
<td>16 or more hours</td>
<td>277</td>
<td>0.3%</td>
</tr>
<tr>
<td>Missing</td>
<td>620</td>
<td>0.7%</td>
</tr>
<tr>
<td>Total</td>
<td>93,606</td>
<td></td>
</tr>
</tbody>
</table>

Source Form: 42
Usage Notes: none
V. Sleep Heart Health Study (SHHS)

Relevant Questions:

A. Past history

1. Has a doctor ever told you that you have the following?
   a. Emphysema
   b. Chronic bronchitis
   c. COPD (chronic obstructive pulmonary disease)
   d. Asthma

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

B. Last night and today

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

3. What time did you go to sleep last night?
   _ _ : _ _ _ _ _ _ A.M. : P.M.
   (Midnight is 12:00 A.M.)

4. How long did you sleep last night?
   _ _ _ _ hours _ _ _ _ minutes

5. How well did you sleep last night?
   1. Much worse than usual
   2. Somewhat worse than usual
   3. As well as usual
   4. A little better than usual
   5. Much better than usual

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

7. How stressful was your day today?
   Was it: (check one)
   1. A typical day
   2. Less stressful than usual
   3. More stressful than usual
C. Restless legs

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

<table>
<thead>
<tr>
<th></th>
<th>YES</th>
<th>NO</th>
<th>Don't know</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. An urge to move your legs</td>
<td>1</td>
<td>0</td>
<td>8</td>
</tr>
<tr>
<td>b. Unpleasant or uncomfortable feelings in your legs</td>
<td>1</td>
<td>0</td>
<td>8</td>
</tr>
</tbody>
</table>

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

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

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

<table>
<thead>
<tr>
<th></th>
<th>YES</th>
<th>NO</th>
<th>Don't know</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Less than once a month</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. About once a month</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. 2-4 days a month</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. 5-15 days a month</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Most days (16-23 days a month)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Daily (6 days a week or more)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th></th>
<th>YES</th>
<th>NO</th>
<th>Don't know</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Hardly at all</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. A little</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Moderately</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. A lot</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Extremely</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

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

<table>
<thead>
<tr>
<th></th>
<th>YES</th>
<th>NO</th>
<th>Don't know</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Resting, sitting or lying down</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Exercising or just stopped exercising</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Standing or walking</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Having a leg cramp or &quot;charlie horse&quot;</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Don't know</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th></th>
<th>YES</th>
<th>NO</th>
<th>Don't know</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th></th>
<th>YES</th>
<th>NO</th>
<th>Don't know</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th></th>
<th>YES</th>
<th>NO</th>
<th>Don't know</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Daytime only (before 6 PM)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Bedtime only</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Evening or nighttime only (after 6 PM)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Both day and night</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th></th>
<th>YES</th>
<th>NO</th>
<th>Don't know</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix I

V. Sleep Heart Health Study (SHHS)

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

______ age in years (approximate OK)

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

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
<th>Don't know</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>0</td>
<td>8</td>
</tr>
</tbody>
</table>

D. Administrative information

Field Site Use Only

17. Interviewer administered in:

☐ English
☐ Spanish
☐ I, akota
☐ Pima
☐ Other, specify: ________________________
☐ Unknown

18. Interviewer or Reviewer: ______ ______ ______

19. Date: ___ ___ — ___ ___ — ___ ___

month day year

20. Comments:

________________________________________

________________________________________

________________________________________
W. National Ambulatory Medical Care Survey

Because sleep-related disorders must be searched by ICD9 Codes, questions are not presented in this appendix.
Appendix II.
Relevant Questions From Selected Large-Sample
Sleep Studies
Table of Contents

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

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

Relevant Questions:

Health & Well-Being Questionnaire

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

Q1

Background details

Male □       Female □

Height_______       Weight_______

Q2

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

Please tick all that apply

□ Anxiety
□ Arthritis
□ Asthma, bronchitis or emphysema
□ Back or spinal problems
□ Cancer
□ Depression or bipolar disorder
□ Diabetes
□ Heart disease
□ High blood pressure
□ High cholesterol
Appendix II A. Corporate British Health Questionnaire

☐ Migraine Headaches
☐ Sinusitis or allergic rhinitis (hayfever)
☐ Any other serious health problem for which you are receiving medical treatment

**Q3**
On average how many units of alcohol do you consume per week

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

**Q4**
Do you smoke every day

☐ No [100]
☐ Yes [0]

**Q5**
How much bodily pain have you experienced during the last 3 months?

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

**Q6**
Which of the following five statements best describes your usual level of physical activity?

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

☐ I often walk places and occasionally exercise enough to cause myself to breathe more heavily than usual, but do this for less than 30 minutes per day [0]
☐ I take regular moderate intensity activity (such as cycling, brisk walking, playing golf or gardening) that causes me to breathe more heavily than usual and sweat. On average I do this for 30 minutes a day on most days of the week [50]

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

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

Q7
How many portions of fibre do you eat a day?

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

Q8
How often do you eat a portion of fruit or vegetables?

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

Q9
When choosing foods for your meal, do you usually select high-fat or low-fat foods?

☐ I choose high-fat foods nearly all the time [0]
☐ I choose high-fat foods most of the time [25]
☐ I choose both high- and low-fat foods equally as often [50]
☐ I choose low-fat foods most of the time [75]
☐ I choose low fat foods all of the time [100]
Q10
On a scale of 1 through to 5 how satisfied are you with your current job?

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

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

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

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

Q11
How much of the time during the last 3 months have you felt calm and peaceful?

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

Q12
How much of the time during the last 3 months did you have a lot of energy?

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

Q13
How much of the time during the last 3 months have you felt depressed or sad?

1 2 3 4 5
☐ ☐ ☐ ☐ ☐
[0] [25] [50] [75] [100]
Q14
How much of the time during the last 3 months have you felt happy?

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

Q15
How do you feel about the coming six months?

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

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

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

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

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

Q16
During the last 3 months how much of the time have you felt overwhelmed with pressure or stress from responsibilities, circumstances or relationships?

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

1 2 3 4 5
□ □ □ □ □
[0] [25] [50] [75] [100]
Appendix II A. Corporate British Health Questionnaire

**Q17**
On average how many hours of sleep do you get a night?

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

**Q18**
In general how happy are you with the amount and quality of sleep that you get?

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

**Q19**
How refreshed and restored do you feel ½ an hour after getting up in the morning?

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

Consider your work responsibilities and how effective you are in accomplishing them. Please answer the following question on the 1 though to 5 scale.
Q20

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

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

1 2 3 4 5
□ □ □ □ □

[0] [25] [50] [75] [100]

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

a. Date of birth

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

Scoring of Questionnaire:

Medical Health Status:

<table>
<thead>
<tr>
<th>Number of medical conditions</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>100</td>
</tr>
<tr>
<td>1</td>
<td>75</td>
</tr>
<tr>
<td>2</td>
<td>50</td>
</tr>
<tr>
<td>3</td>
<td>25</td>
</tr>
<tr>
<td>4+</td>
<td>0</td>
</tr>
</tbody>
</table>

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
Appendix II

A. Corporate British Health Questionnaire

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

<table>
<thead>
<tr>
<th>Body Mass Index</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;18.5</td>
<td>50</td>
</tr>
<tr>
<td>18.5 to &lt;25</td>
<td>100</td>
</tr>
<tr>
<td>25 to &lt;30</td>
<td>25</td>
</tr>
<tr>
<td>≥30</td>
<td>0</td>
</tr>
</tbody>
</table>

This questionnaire and its associated scoring is the copyright of Vielife Ltd. It is free to use, however all we ask is that you inform us of where you intend to use it and share any pertinent research findings (contact information: email: p.mills@vielife.com telephone: +44-20-7571 3836).
### B. Chronic Fatigue Syndrome and Sleep Assessment

#### Relevant Questions:

The Sleep Assessment Questionnaire©

<table>
<thead>
<tr>
<th>Patient Name:</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Today's Date:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Height:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Weight:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Date of Birth:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

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

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

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

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

Sample Characteristics:

**TABLE 1.** Demographic Data of Study Population

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

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

Health-Related Quality of Life Questionnaire

Appendix A. CDC HRQOL Items

1. Would you say that in general your health is: Excellent, Very good, Good, Fair, or Poor?

2. Now thinking about your physical health, which includes physical illness and injury, for how many days during the past 30 days was your physical health not good?

3. Now thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?

4. During the past 30 days, for about how many days did poor physical or mental health keep you from doing your usual activities, such as self-care, work, or recreation?

5. During the past 30 days, for about how many days did pain make it hard for you to do your usual activities, such as self-care, work, or recreation?

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

7. During the past 30 days, for about how many days have you felt very healthy and full of energy?

8. Are you limited in any way in any activities because of any impairment or health problem?

9. Because of any impairment or health problem, do you need the help of other persons with your personal care needs, such as eating, bathing, dressing, or getting around the house?
F. Pediatric Sleep Medicine Survey

Relevant Questions:

**PEDIATRIC SLEEP SURVEY**

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.

2) Children with delayed sleep phase ("Night Owls") may present with bedtime resistance.

3) The incidence of Obstructive Sleep Apnea Syndrome (OSAS) in preschoolers is less than 1%.

4) Night terrors and sleepwalking often have a familial component.

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

   b. Requires an overnight sleep study and Multiple Sleep Latency Test (MSLT) to diagnose

   c. Psychostimulants are usually the treatment of choice

6) Bright light phototherapy with a light box may be helpful for children with a delayed sleep phase.

7) Children with ADHD seldom have sleep onset difficulties unless they are on psychostimulant medication.

8) It is normal for school-aged children to take naps up to several times a week.

9) Breast-fed babies usually sleep through the night at an earlier age than bottle-fed babies.

10) Hyperactivity is a common presenting complaint in pediatric OSAS.

11) Amnesia for the episode is not helpful in distinguishing night terrors from nightmares.

12) Children with severe developmental delays have an increased risk of developing sleep schedule disturbances.

13) Average 24-hour total sleep duration for a 3-year old is about 8 hours.

14) Health care providers should not recommend temporary establishment of a later bedtime as an intervention for a child with difficulty falling asleep.

15) No combination of clinical symptom severity and physical findings reliably predicts disease severity in children with OSAS.

16) Nocturnal bedwetting occurs almost exclusively during deep or slow-wave sleep.
17) School avoidance makes a sleep phase delay in adolescents more difficult to treat.  

18) It is normal for young children to awaken briefly during the night at the end of a sleep cycle (every 60-90 minutes).  

19) "Learned Hunger" resulting from frequent night feedings can lead to increased nocturnal awakenings in infants.  

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  
   b. Down Syndrome  
   c. Repaired Cleft Palate  
   d. Achondroplasia  

21) Bruxism (teeth grinding) is uncommon in children.  

22) Head banging in infants at bedtime is usually associated with developmental delay.  

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  
   b. May be linked to symptoms of Attention Deficit Hyperactivity Disorder  
   c. May be cause of "growing pains" in children  

II. The purpose of this next section of the survey is to assess how physicians screen, evaluate, and treat childhood sleep disorders in their own practices. Please answer based on what you actually do, rather than what you think you should do for the following:
<table>
<thead>
<tr>
<th>Item</th>
<th>Infants (0-1 Yrs)</th>
<th>Toddlers/Pre-School (2-4 Yrs)</th>
<th>School-Aged (5-12 Yrs)</th>
<th>Adolescents (13+ Yrs)</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. do not screen for sleep problems in this age group</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. generally ask single question only about general sleep problems</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. usual bedtime</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. usual wake time</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>e. usual sleep amount</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>f. naps</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>g. regularity of sleep-wake schedule</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>h. co-sleeping</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>i. bedtime resistance</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>j. sleep onset delay</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>k. night wakings</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>l. nighttime fears</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>m. sleepwalking</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>n. night terrors</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>o. nightmares</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>p. bedwetting</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>q. teeth grinding</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>r. frequent leg kicking or twitching during sleep</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>s. snoring</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>t. breathing pauses</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>u. restless sleep</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>v. difficulty am waking</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>w. daytime sleepiness</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>x. daytime behavior problems</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>y. family history of sleep problems</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>z. question child about sleep habits</td>
<td></td>
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</tr>
</tbody>
</table>

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.

2) In a pre-schooler with **bedtime resistance**, ask about parental disciplinary style.

3) In school-aged children with **secondary enuresis**, inquire about a history of snoring.

4) Ask about the timing of the night wakings in evaluating a child for **parasomnias**.

5) Routinely inquire about symptoms of cataplexy in adolescents with profound **daytime sleepiness**.

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:
   b. refer to a sleep subspecialist or sleep clinic for evaluation:
   c. refer for an in-hospital overnight sleep study:
   d. refer directly to an otolaryngologist

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
   b. advise increasing the level of parental intervention at bedtime
   c. advise gradually increasing time intervals between “checking on” child (“Ferber Method”)
   d. advise parents that problem will resolve without intervention

2) **Bedtime resistance** in a pre-schooler due to sudden onset of nighttime fears:
   a. advise ignoring fears and setting firm limits at bedtime
   b. suggest transitional object
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:

<table>
<thead>
<tr>
<th>Area</th>
<th>Not Important</th>
<th>Somewhat Important</th>
<th>Very Important</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) general health</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2) mood and behavior</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3) academic performance</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4) parental stress</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>5) non-intentional injury rates (falls, burns, etc.)</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Issue</th>
<th>Not Important</th>
<th>Somewhat Important</th>
<th>Very Important</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) educating adolescents about drowsy driving</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2) delaying high school start times</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3) educating school personnel about children’s sleep</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

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)

C. Your ability to screen children for sleep problems
D. Your ability to evaluate children for sleep problems
E. Your ability to manage children with sleep problems

Please estimate the following: (Circle one)

F. Overall percentage of patients in your practice with sleep problems:
   - 0-25% 26-50% 51-75% 76-100%
   - 1 | 2 | 3 | 4 | 5

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

<table>
<thead>
<tr>
<th>Never</th>
<th>Rarely</th>
<th>Sometimes</th>
<th>Usually</th>
<th>Always</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**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 hard 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

B. Epworth Sleepiness Scale ........................................................................................................ III–7  
C. Exempla Healthcare Sleep Disorders Laboratory: Patient Education and Screening Questionnaire ........................................................................................................ III–9  
D. Infant Screening Questionnaire ............................................................................................. III–10  
E. Leeds Sleep Evaluation Questionnaire .................................................................................. III–11  
F. Maternal Child Supervision Questionnaire, 1961 ................................................................ III–13  
G. Parental Interactive Bedtime Behavior Scale ........................................................................ III–16  
H. Pediatric Sleep Questionnaire .............................................................................................. III–18  
I. Sinai Hospital Sleep Disorder Assessment Questionnaire .................................................. III–27  
J. Sleep Apnea—The Phantom of the Night Questionnaire ................................................... III–29  
K. Pittsburgh Sleep Quality Index ............................................................................................. III–32  
L. Stanford Sleepiness Scale ..................................................................................................... III–37  
M. Functional Outcomes of Sleep Questionnaire ..................................................................... III–38
Sleep Apnea Questionnaire

Relevant Questions:

Circle the numbers of the comments that apply to you.

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

23. I frequently feel depressed.

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

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

26. I have short term memory problems.

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

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

29. I’m tired all the time.

30. I have great difficulty concentrating.

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

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

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

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

Relevant Questions:

**EPWORTH SLEEPINESS SCALE**

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

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

<table>
<thead>
<tr>
<th>Situation</th>
<th>Chance of Dozing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sitting &amp; Reading</td>
<td></td>
</tr>
<tr>
<td>Watching TV</td>
<td></td>
</tr>
<tr>
<td>Sitting inactive in a public place (i.e. theatre)</td>
<td></td>
</tr>
<tr>
<td>As a car passenger for an hour without a break</td>
<td></td>
</tr>
<tr>
<td>Lying down to rest in the afteroon</td>
<td></td>
</tr>
<tr>
<td>Sitting &amp; talking to someone</td>
<td></td>
</tr>
<tr>
<td>Sitting quietly after lunch without alcohol</td>
<td></td>
</tr>
<tr>
<td>In a car, while stopping for a few minutes in traffic</td>
<td></td>
</tr>
</tbody>
</table>

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

**EPWORTH SLEEPINESS SCALE:**

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

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

<table>
<thead>
<tr>
<th>SITUATIONS</th>
<th>SCALE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sitting and talking to someone</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>Sitting inactive in a public place</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>Sitting quietly after lunch without alcohol</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>Sitting and reading</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>Watching television</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>Lying down to rest in the afternoon</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>In a car, while stopped in traffic</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>As a passenger in a car</td>
<td>0 1 2 3</td>
</tr>
</tbody>
</table>
Appendix III

B. Epworth Sleepiness Scale

Severity of Daytime Sleepiness Scale

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

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

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

Is your level of sleepiness: None _____  Mild _____  Moderate _____  Severe _____ ?

Refer to Sleepiness Scale above.

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING BELOW

OR PROVIDE A LIST THAT CAN BE COPIED.

INCLUDE NON-PRESCRIPTION DRUGS AND VITAMINS.

<table>
<thead>
<tr>
<th>Name of Medication</th>
<th>Dose - mg/day and time of day you take it</th>
<th>For how long have you taken this medication?</th>
<th>Reason you are taking this medication.</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>
C. Exempla Healthcare Sleep Disorders Laboratory: Patient Education and Screening Questionnaire

Relevant Questions:

**Patient Name:** _____________________________
**Age:** _______  **Sex:** _______
**Height:** _______  **Weight:** _______  **Neck Size:** _______

**PATIENT EDUCATION AND SCREENING QUESTIONNAIRE**

*PLEASE COMPLETE QUESTIONNAIRE & fax to the SLEEP LAB at 303-403-3635 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 ____
Appendix III  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.

D. Infant Screening Questionnaire

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

Is your weight stable? Yes ___ No ___

Have you gained weight ___ or lost weight ___? # of pounds ______ Over what course of time? _________________

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

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

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

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

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

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

Do you dream during these attacks? Yes ___ No ___

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

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

Has your nose ever been broken? Yes ___ No ___ How and when? ________________________________

Do you have a deviated septum? Yes ___ No ___

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

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

Have you had any other nasal or throat surgery? Yes ___ No ___ Explain ______________________________

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

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

Do you have any additional comments or observations? ________________________________

Do you have any drug allergies? ____________________________________________________________

Patient Name ________________________________
Relevant Questions:

Brief Infant Screening Questionnaire

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

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

In what position does your child sleep most of the time?
□ On his/her belly  □ On his/her side  □ On his/her back

How much time does your child spend in sleep during the NIGHT (between 7 in the evening and 7 in the morning)?

Hours: ________ Minutes: ________

How much time does your child spend in sleep during the DAY (between 7 in the morning and 7 in the evening)?

Hours: ________ Minutes: ________

Average number of night wakings per night:

How much time during the night does your child spend in wakefulness (from 10 in the evening to 6 in the morning)?

Hours: ________ Minutes: ________

How long does it take to put your baby to sleep in the evening?

Hours: ________ Minutes: ________

How does your baby fall asleep?
□ While feeding  □ Being rocked  □ Being held
□ In bed alone  □ In bed near parent

When does your baby usually fall asleep for the night?

Hours: ________ Minutes: ________

Do you consider your child’s sleep as a problem?
□ A very serious problem  □ A small problem  □ Not a problem at all

E. Leeds Sleep Evaluation Questionnaire

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

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

**Relevant Questions:**

**The Leeds Sleep Evaluation Questionnaire**

1. How would you compare getting to sleep using the medication with getting to sleep normally (i.e. without medication)?
   - Harder than usual/easier than usual
   - Slower than usual/quicker than usual
   - Felt less drowsy than usual/felt more drowsy than usual.

2. How would you compare the quality of sleep using the medication with nonmedicated (your usual) sleep?
   - More restless than usual/more restful than usual
   - More periods of wakefulness than usual/fewer periods of wakefulness than usual.

3. How did your awakening after medication compare with your usual pattern of awakening?
   - More difficult than usual/easier than usual
   - Took longer than usual/took shorter than usual
4. How did you feel on wakening?
   □ Tired/alert

5. How do you feel now?
   □ Tired/alert.

6. How was your sense of balance and coordination upon getting up?
   □ More clumsy than usual/less clumsy than usual

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

F. Maternal Child Supervision Questionnaire, 1961

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

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

Relevant Questions:

CHILD DEVELOPMENT

APPENDIX

DUPLICATE OF STUDY QUESTIONNAIRE

Baby’s date of birth ________________  Today’s date ________________
Baby’s weight at birth ________________  Mother’s age ________________
Baby is a boy □  girl □  How many other children do you have? ___

The following list is based on doctors’ reports of the many questions or worries that mothers sometimes have about their new babies. Which of these, if any, have worried you about your baby?
<table>
<thead>
<tr>
<th>Item</th>
<th>No Worry (check)</th>
<th>Some Worry (check)</th>
<th>Considerable Worry (check)</th>
<th>Please Describe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stomach (too large, small, hard, soft, swollen, etc.)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Breathing (uneven, hiccoughs, gags, chokes, gasps, grunts, etc.)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Hair (too much, too little, falling out, etc.)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Eyes (puffy, red, crossed, color, etc.)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Ears (shape, size, color, etc.)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td></td>
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<tr>
<td>Nose (size, shape, running, etc.)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td></td>
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<tr>
<td>Mouth-Lips (size, shape, color, sore, swallowing, thumb-sucking, etc.)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Sleeping (too much, not enough, not regular, restless, etc.)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Accidents (while sleeping, eating, playing, bathing, etc.)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Head (size, shape, soft spot, etc.)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td></td>
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<tr>
<td>Weight (not gaining, too fat, too thin, etc.)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Crying (too much, too little, strong, weak, turns color, etc.)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
</tbody>
</table>
**DUPLICATE OF STUDY QUESTIONNAIRE** (continued from previous page)

<table>
<thead>
<tr>
<th>Item</th>
<th>Yes</th>
<th>No</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>NAVEL (swollen, too large, small, bleeding, odor, etc.)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>BUTTOCKS (diaper rash, sore, color, etc.)</td>
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<td></td>
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<tr>
<td>SKIN (oily, dry, rash, scratches, etc.)</td>
<td></td>
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<td></td>
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<tr>
<td>BOWEL MOVEMENTS (odor, color, too often, too loose, hard, etc.)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>URINE (odor, color, too often, too little, etc.)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>EATING (not enough, too much, not regular, hungry, disagrees, etc.)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DIGESTION (spitting, burping, gas, vomiting, colic, etc.)</td>
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<td></td>
<td></td>
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<tr>
<td>LEGS-FEET (too thin, too heavy, not straight, etc.)</td>
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<td></td>
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<tr>
<td>ARMS-HANDS (too thin, too heavy, not straight, etc.)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>OTHER (spoiling baby, food preparation, bathing, clothing, diapering, etc.)</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Have you chosen a doctor to care for your baby yet?</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>If yes, has the doctor examined your baby in— (Please check)</td>
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<td></td>
</tr>
<tr>
<td>a. the hospital</td>
<td></td>
<td></td>
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<tr>
<td>b. the office</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. your home</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>d. baby not examined by doctor yet</td>
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<td></td>
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<tr>
<td>Did the doctor mention anything about your baby that would need special care or attention? (Please explain)</td>
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<td>About yourself, how many years were you in—</td>
<td>Grade School</td>
<td>yrs.</td>
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</tr>
<tr>
<td>High School</td>
<td>yrs.</td>
<td>College</td>
<td>yrs.</td>
</tr>
<tr>
<td>Comments</td>
<td></td>
<td></td>
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G. Parental Interactive Bedtime Behavior Scale

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

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

The Parental Interactive Bedtime Behaviour Scale (PIBBS)

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

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

Office Use only

**Strategies**

<table>
<thead>
<tr>
<th>Sub-scale score</th>
<th>% Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Active physical comforting (items, $1+2+3+12+15+17$)</td>
<td>$\frac{24 \times 100}{a}$</td>
</tr>
<tr>
<td>Encourage autonomy (items $6+11+13$)</td>
<td>$\frac{12 \times 100}{b}$</td>
</tr>
<tr>
<td>Settle by movement (items $4+5$)</td>
<td>$\frac{8 \times 100}{c}$</td>
</tr>
<tr>
<td>Passive physical comforting (items $14+16$)</td>
<td>$\frac{8 \times 100}{d}$</td>
</tr>
<tr>
<td>Social comforting (items $7+8+9+10$)</td>
<td>$\frac{16 \times 100}{e}$</td>
</tr>
</tbody>
</table>

Total % score = $(a-b+c+d+e+100)/5 = \square$
H. Pediatric Sleep Questionnaire

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

Relevant Questions:

Child’s Name: ___________________  ___________________  ___________________
                   (Last)    (First)     (M.I.)

Name of Person Answering Questions: ________________________

Relation to Child: ______________________

Your phone number (please include area code):
days: __________  evenings: __________

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

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

<table>
<thead>
<tr>
<th>Today’s Date:</th>
<th>Office use only</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>GI2</td>
</tr>
<tr>
<td>Where are you completing this questionnaire?</td>
<td>GI3</td>
</tr>
<tr>
<td>Date of Child’s Birth:</td>
<td>GI4</td>
</tr>
<tr>
<td>Sex: Male or Female?</td>
<td>GI5</td>
</tr>
<tr>
<td>Current Height (feet/inches):</td>
<td>GI6</td>
</tr>
<tr>
<td>Current Weight (pounds):</td>
<td>GI7</td>
</tr>
<tr>
<td>Grade in school (if applicable):</td>
<td>GI8</td>
</tr>
<tr>
<td>Racial/Ethnic Background of your Child (please circle):</td>
<td>GI9</td>
</tr>
</tbody>
</table>

1.) American Indian  
2.) Asian-American  
3.) African-American  
4.) Hispanic  
5.) White/not Hispanic  
6.) Other or unknown
### A. Nighttime and sleep behavior: WHILE SLEEPING, DOES YOUR CHILD ...

<table>
<thead>
<tr>
<th>Question</th>
<th>Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>... ever snore?</td>
<td>Y N DK</td>
</tr>
<tr>
<td>... snore more than half the time?</td>
<td>Y N DK</td>
</tr>
<tr>
<td>... always snore?</td>
<td>Y N DK</td>
</tr>
<tr>
<td>... snore loudly?</td>
<td>Y N DK</td>
</tr>
<tr>
<td>... have “heavy” or loud breathing?</td>
<td>Y N DK</td>
</tr>
<tr>
<td>... have trouble breathing, or struggle to breathe? HAVE YOU EVER ...</td>
<td>Y N DK</td>
</tr>
<tr>
<td>... seen your child stop breathing during the night? If so, please describe what has happened:</td>
<td>Y N DK</td>
</tr>
<tr>
<td>... been concerned about your child’s breathing during sleep?</td>
<td>Y N DK</td>
</tr>
<tr>
<td>... had to shake your sleeping child to get him or her to breathe, or wake up and breathe?</td>
<td>Y N DK</td>
</tr>
<tr>
<td>... seen your child wake up with a snorting sound? DOES YOUR CHILD ...</td>
<td>Y N DK</td>
</tr>
<tr>
<td>... have restless sleep?</td>
<td>Y N DK</td>
</tr>
<tr>
<td>... 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 ...</td>
<td>Y N DK Y N DK Y</td>
</tr>
<tr>
<td>... 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 ...</td>
<td>Y N DK Y N DK</td>
</tr>
<tr>
<td>... become sweaty, or do the pajamas usually become wet with perspiration?</td>
<td>Y N DK</td>
</tr>
<tr>
<td>... get out of bed (for any reason)?</td>
<td>Y N DK</td>
</tr>
<tr>
<td>... get out of bed to urinate? If so, how many times each night, on average?</td>
<td>Y N DK</td>
</tr>
<tr>
<td>Does your child usually sleep with the mouth open?</td>
<td>Y N DK</td>
</tr>
<tr>
<td>Is your child’s nose usually congested or “stuffed” at night?</td>
<td>Y N DK</td>
</tr>
<tr>
<td>Do any allergies affect your child’s ability to breathe through the nose?</td>
<td>Y N DK</td>
</tr>
<tr>
<td>... tend to breathe through the mouth during the day?</td>
<td>Y N DK</td>
</tr>
<tr>
<td>Question</td>
<td>Y</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>---</td>
</tr>
<tr>
<td>... have a dry mouth on waking up in the morning?</td>
<td></td>
</tr>
<tr>
<td>... complain of an upset stomach at night?</td>
<td></td>
</tr>
<tr>
<td>... get a burning feeling in the throat at night?</td>
<td></td>
</tr>
<tr>
<td>... grind his or her teeth at night?</td>
<td></td>
</tr>
<tr>
<td>... occasionally wet the bed?</td>
<td></td>
</tr>
<tr>
<td>Has your child ever walked during sleep (&quot;sleep walking&quot;)?</td>
<td></td>
</tr>
<tr>
<td>Have you ever heard your child talk during sleep (&quot;sleep talking&quot;)?</td>
<td></td>
</tr>
<tr>
<td>Does your child have nightmares once a week or more on average?</td>
<td></td>
</tr>
<tr>
<td>Has your child ever woken up screaming during the night?</td>
<td></td>
</tr>
<tr>
<td>Has your child ever been moving or behaving, at night, in a way that</td>
<td></td>
</tr>
<tr>
<td>made you think your child was neither completely awake nor asleep?</td>
<td></td>
</tr>
<tr>
<td>If so, please describe what has happened:</td>
<td></td>
</tr>
<tr>
<td>Does your child have difficulty falling asleep at night?</td>
<td></td>
</tr>
<tr>
<td>How long does it take your child to fall asleep at night? (a guess is</td>
<td></td>
</tr>
<tr>
<td>O.K.)</td>
<td></td>
</tr>
<tr>
<td>At bedtime does your child usually have difficult &quot;routines&quot; or</td>
<td></td>
</tr>
<tr>
<td>&quot;rituals,&quot; argue a lot, or otherwise behave badly?</td>
<td></td>
</tr>
<tr>
<td>DOES YOUR CHILD ... bang his or her head or rock his or her body when</td>
<td></td>
</tr>
<tr>
<td>going to sleep?</td>
<td></td>
</tr>
<tr>
<td>... wake up more than twice a night on average?</td>
<td></td>
</tr>
<tr>
<td>... have trouble falling back asleep if he or she wakes up at night?</td>
<td></td>
</tr>
<tr>
<td>... wake up early in the morning and have difficulty going back to</td>
<td></td>
</tr>
<tr>
<td>sleep?                    .</td>
<td></td>
</tr>
<tr>
<td>Does the time at which your child goes to bed change a lot from day to</td>
<td></td>
</tr>
<tr>
<td>day?                      WHAT TIME DOES YOUR CHILD USUALLY ...</td>
<td></td>
</tr>
<tr>
<td>... go to bed during the week?</td>
<td></td>
</tr>
<tr>
<td>... go to bed on the weekend or vacation?</td>
<td></td>
</tr>
<tr>
<td>... get out of bed on weekday mornings?</td>
<td></td>
</tr>
<tr>
<td>... get out of bed on weekend or vacation mornings?</td>
<td></td>
</tr>
<tr>
<td>B. Daytime behavior and other possible problems:</td>
<td>DOES YOUR CHILD …</td>
</tr>
<tr>
<td>-------------------------------------------------</td>
<td>-------------------</td>
</tr>
<tr>
<td>… wake up feeling unrefreshed in the morning?</td>
<td>Y N DK</td>
</tr>
<tr>
<td>… have a problem with sleepiness during the day?</td>
<td>Y N DK</td>
</tr>
<tr>
<td>… complain that he or she feels sleepy during the day?</td>
<td>Y N DK</td>
</tr>
<tr>
<td>Has a teacher or other supervisor commented that your child appears sleepy during the day?</td>
<td>Y N DK</td>
</tr>
<tr>
<td>Does your child usually take a nap during the day?</td>
<td>Y N DK</td>
</tr>
<tr>
<td>Is it hard to wake your child up in the morning?</td>
<td>Y N DK</td>
</tr>
<tr>
<td>Does your child wake up with headaches in the morning?</td>
<td>Y N DK</td>
</tr>
<tr>
<td>Does your child get a headache at least once a month, on average?</td>
<td>Y N DK</td>
</tr>
<tr>
<td>Did your child stop growing at a normal rate at any time since birth? If so, please describe what happened:</td>
<td>Y N DK</td>
</tr>
<tr>
<td>Does your child still have tonsils? If not, when and why were they removed?: HAS YOUR CHILD EVER …</td>
<td>Y N DK</td>
</tr>
<tr>
<td>… had a condition causing difficulty with breathing? If so, please describe:</td>
<td>Y N DK</td>
</tr>
<tr>
<td>… had surgery? If so, did any difficulties with breathing occur before, during, or after surgery?</td>
<td>Y N DK Y N DK</td>
</tr>
<tr>
<td>… become suddenly weak in the legs, or anywhere else, after laughing or being surprised by something?</td>
<td>Y N DK</td>
</tr>
<tr>
<td>… felt unable to move for a short period, in bed, though awake and able to look around?</td>
<td>Y N DK</td>
</tr>
<tr>
<td>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?</td>
<td>Y N DK</td>
</tr>
<tr>
<td>Has your child ever sensed that he or she was dreaming (seeing images or hearing sounds) while still awake?</td>
<td>Y N DK</td>
</tr>
<tr>
<td>Does your child drink caffeinated beverages on a typical day (cola, tea, coffee)? If so, how many cups or cans per day?</td>
<td>Y N DK</td>
</tr>
<tr>
<td>Does your child use any recreational drugs? If so, which ones and how often?:</td>
<td>Y N DK</td>
</tr>
<tr>
<td>Does your child use cigarettes, smokeless tobacco, snuff, or other tobacco products? If so, which ones and how often?:</td>
<td>Y N DK</td>
</tr>
<tr>
<td>Question</td>
<td>Y</td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
<td>---</td>
</tr>
<tr>
<td>Is your child overweight? If so, at what age did this first develop?</td>
<td></td>
</tr>
<tr>
<td>Has a doctor ever told you that your child has a high-arched palate (roof of the mouth)?</td>
<td></td>
</tr>
<tr>
<td>Has your child ever taken Ritalin (methylphenidate) for behavioral problems?</td>
<td></td>
</tr>
<tr>
<td>Has a health professional ever said that your child has attention-deficit disorder (ADD) or attention-deficit/hyperactivity disorder (ADHD)?</td>
<td></td>
</tr>
</tbody>
</table>
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:

<table>
<thead>
<tr>
<th>Medicine</th>
<th>Size (mg) or amount per dose</th>
<th>Taken when?</th>
<th>Effect: ________________________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>________</td>
<td>________________________</td>
<td>__________</td>
<td></td>
</tr>
<tr>
<td></td>
<td>________________________</td>
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<td></td>
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<tr>
<td></td>
<td>________________________</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Effect:</td>
<td>________________________________</td>
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<tr>
<td>________</td>
<td>________________________</td>
<td>__________</td>
<td></td>
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<tr>
<td>Effect:</td>
<td>________________________________</td>
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<tr>
<td>________</td>
<td>________________________</td>
<td>__________</td>
<td></td>
</tr>
<tr>
<td>Effect:</td>
<td>________________________________</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
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:

<table>
<thead>
<tr>
<th>Medicine</th>
<th>Size (mg) or amount per dose</th>
<th>Taken how often?</th>
<th>Dates Taken</th>
<th>Effect</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Effect:</td>
<td></td>
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<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Effect:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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:

<table>
<thead>
<tr>
<th>Relative</th>
<th>Condition</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
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:

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

THANK YOU
### I. Sinai Hospital Sleep Disorder Assessment Questionnaire

#### Relevant Questions:

**Sleep questionnaire #1**

Sleep medicine specialists use the Epworth Sleepiness Scale to identify the level of daytime 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

<table>
<thead>
<tr>
<th>Score Range</th>
<th>Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>5-9</td>
<td>Discuss complaints with your doctor.</td>
</tr>
<tr>
<td>10-14</td>
<td>Important to discuss with your doctor (consider sleep evaluation).</td>
</tr>
<tr>
<td>15-19</td>
<td>Sleep consultation or sleep study suggested.</td>
</tr>
<tr>
<td>20+</td>
<td>Significant risk of sleep apnea. Sleep study should be scheduled.</td>
</tr>
</tbody>
</table>
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?
Appendix III  J. Sleep Apnea—The Phantom of the Night Questionnaire

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

**While awake**

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

**Adjustment and emotional issues**

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

**Medical, physical condition, and lifestyle**

- Are you overweight?
- Do you have high blood pressure? Is it hard to control?
- Do you have heart disease? Do you have difficulty controlling the symptoms with medication?
- Do you have pains in your bones and joints?
- Do you have trouble breathing through your nose?
• Do you often have a drink of alcohol before going to bed?
• Do you have a small chin and receding jaw?
• If you are a man, is your collar size 17 inches (42 centimeters) or larger?
• Have you been diagnosed with severe esophageal reflux?
• Do you have family members or relatives who have sleep apnea?

What your answers may mean

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

### Appendix. Pittsburgh Sleep Quality Index (PSQI)

Name ____________________ ID # __________ Date __________ Age ______

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

1. During the past month, when have you usually gone to bed at night?
   
   **USUAL BED TIME __________

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

3. During the past month, when have you usually gotten up in the morning?
   
   **USUAL GETTING UP TIME __________

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

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

5. During the past month, how often have you had trouble sleeping because you...
   
   (a) Cannot get to sleep within 30 minutes
      
      Not during the past month _____ once a week _____ twice a week _____ times a week _____

   (b) Wake up in the middle of the night or early morning
      
      Not during the past month _____ once a week _____ twice a week _____ times a week _____

   (c) Have to get up to use the bathroom
      
      Not during the past month _____ once a week _____ twice a week _____ times a week _____

   (d) Cannot breathe comfortably
      
      Not during the past month _____ once a week _____ twice a week _____ times a week _____

   (e) Cough or snore loudly
      
      Not during the past month _____ once a week _____ twice a week _____ times a week _____

   (f) Feel too cold
      
      Not during the past month _____ once a week _____ twice a week _____ times a week _____

   (g) Feel too hot
      
      Not during the past month _____ once a week _____ twice a week _____ times a week _____

   (h) Had bad dreams
      
      Not during the past month _____ once a week _____ twice a week _____ times a week _____

   (i) Have pain
      
      Not during the past month _____ once a week _____ twice a week _____ times a week _____
(j) Other reason(s), please describe ________________________________________________________________________________________________

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

<table>
<thead>
<tr>
<th>Not during the past month</th>
<th>Less than once a week</th>
<th>Once or twice a week</th>
<th>Three or more times a week</th>
</tr>
</thead>
</table>

6. During the past month, how would you rate your sleep quality overall?

- Very good _______
- Fairly good _______
- Fairly bad _______
- Very bad _______

7. During the past month, how often have you taken medicine (prescribed or “over the counter”) to help you sleep?

<table>
<thead>
<tr>
<th>Not during the past month</th>
<th>Less than once a week</th>
<th>Once or twice a week</th>
<th>Three or more times a week</th>
</tr>
</thead>
</table>

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

<table>
<thead>
<tr>
<th>Not during the past month</th>
<th>Less than once a week</th>
<th>Once or twice a week</th>
<th>Three or more times a week</th>
</tr>
</thead>
</table>

9. During the past month, how much of a problem has it been for you to keep up enough enthusiasm to get things done?

- No problem at all _______
- Only a very slight problem _______
- Somewhat of a problem _______
- A very big problem _______

10. Do you have a bed partner or roommate?

- No bed partner or roommate _______
- Partner/roommate in other room _______
- Partner in same room, but not same bed _______
- Partner in same bed _______

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

(a) Loud snoring

<table>
<thead>
<tr>
<th>Not during the past month</th>
<th>Less than once a week</th>
<th>Once or twice a week</th>
<th>Three or more times a week</th>
</tr>
</thead>
</table>

(b) Long pauses between breaths while asleep

<table>
<thead>
<tr>
<th>Not during the past month</th>
<th>Less than once a week</th>
<th>Once or twice a week</th>
<th>Three or more times a week</th>
</tr>
</thead>
</table>

(c) Legs twitching or jerking while you sleep

<table>
<thead>
<tr>
<th>Not during the past month</th>
<th>Less than once a week</th>
<th>Once or twice a week</th>
<th>Three or more times a week</th>
</tr>
</thead>
</table>

(d) Episodes of disorientation or confusion during sleep

<table>
<thead>
<tr>
<th>Not during the past month</th>
<th>Less than once a week</th>
<th>Once or twice a week</th>
<th>Three or more times a week</th>
</tr>
</thead>
</table>

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

<table>
<thead>
<tr>
<th>Not during the past month</th>
<th>Less than once a week</th>
<th>Once or twice a week</th>
<th>Three or more times a week</th>
</tr>
</thead>
</table>
Scoring Instructions for the Pittsburgh Sleep Quality Index

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

Scoring proceeds as follows:

Component 1: Subjective sleep quality
Examine question #6, and assign scores as follows:

<table>
<thead>
<tr>
<th>Response</th>
<th>Component 1 score</th>
</tr>
</thead>
<tbody>
<tr>
<td>&quot;Very good&quot;</td>
<td>0</td>
</tr>
<tr>
<td>&quot;Fairly good&quot;</td>
<td>1</td>
</tr>
<tr>
<td>&quot;Fairly bad&quot;</td>
<td>2</td>
</tr>
<tr>
<td>&quot;Very bad&quot;</td>
<td>3</td>
</tr>
</tbody>
</table>

Component 1 score: _______

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

<table>
<thead>
<tr>
<th>Response</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>≤ 15 minutes</td>
<td>0</td>
</tr>
<tr>
<td>16-30 minutes</td>
<td>1</td>
</tr>
<tr>
<td>31-60 minutes</td>
<td>2</td>
</tr>
<tr>
<td>&gt; 60 minutes</td>
<td>3</td>
</tr>
</tbody>
</table>

Question #2 score: _______

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

<table>
<thead>
<tr>
<th>Response</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not during the past month</td>
<td>0</td>
</tr>
<tr>
<td>Less than once a week</td>
<td>1</td>
</tr>
<tr>
<td>Once or twice a week</td>
<td>2</td>
</tr>
<tr>
<td>Three or more times a week</td>
<td>3</td>
</tr>
</tbody>
</table>

Question #5a score: _______

3. Add #2 score and #5a score

Sum of #2 and #5a: _______

4. Assign component 2 score as follows:

<table>
<thead>
<tr>
<th>Sum of #2 and #5a</th>
<th>Component 2 score</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>1-2</td>
<td>1</td>
</tr>
<tr>
<td>3-4</td>
<td>2</td>
</tr>
<tr>
<td>5-6</td>
<td>3</td>
</tr>
</tbody>
</table>

Component 2 score: _______

Component 3: Sleep duration
Examine question #4, and assign scores as follows:

<table>
<thead>
<tr>
<th>Response</th>
<th>Component 3 score</th>
</tr>
</thead>
<tbody>
<tr>
<td>&gt; 7 hours</td>
<td>0</td>
</tr>
<tr>
<td>6-7 hours</td>
<td>1</td>
</tr>
<tr>
<td>5-6 hours</td>
<td>2</td>
</tr>
<tr>
<td>&lt; 5 hours</td>
<td>3</td>
</tr>
</tbody>
</table>

Component 3 score: _______
Component 4: Habitual sleep efficiency
(1) Write the number of hours slept (question # 4) here: _________
(2) Calculate the number of hours spent in bed:
   Getting up time (question # 3): _________
   Bedtime (question # 1): _________
   Number of hours spent in bed: _________
(3) Calculate habitual sleep efficiency as follows:
   \[
   \text{Habitual sleep efficiency} = \frac{\text{Number of hours slept}}{\text{Number of hours spent in bed}} \times 100 = \text{Habitual sleep efficiency} \%
   \]
(4) Assign component 4 score as follows:

<table>
<thead>
<tr>
<th>Habitual sleep efficiency %</th>
<th>Component 4 score</th>
</tr>
</thead>
<tbody>
<tr>
<td>&gt; 85%</td>
<td>0</td>
</tr>
<tr>
<td>75-84%</td>
<td>1</td>
</tr>
<tr>
<td>65-74%</td>
<td>2</td>
</tr>
<tr>
<td>&lt; 65%</td>
<td>3</td>
</tr>
</tbody>
</table>

Component 4 score: _________

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

<table>
<thead>
<tr>
<th>Response</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not during the past month</td>
<td>0</td>
</tr>
<tr>
<td>Less than once a week</td>
<td>1</td>
</tr>
<tr>
<td>Once or twice a week</td>
<td>2</td>
</tr>
<tr>
<td>Three or more times a week</td>
<td>3</td>
</tr>
</tbody>
</table>

#5b score ________  c score ________
d score ________  e score ________
f score ________  g score ________
h score ________  i score ________
j score ________

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

\[
\text{Sum of # 5b-5j: } = \text{sum of individual scores}
\]

(3) Assign component 5 score as follows:

<table>
<thead>
<tr>
<th>Sum of # 5b-5j</th>
<th>Component 5 score</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>1-9</td>
<td>1</td>
</tr>
<tr>
<td>10-18</td>
<td>2</td>
</tr>
<tr>
<td>19-27</td>
<td>3</td>
</tr>
</tbody>
</table>

Component 5 score: _________

Component 6: Use of sleeping medication
Examine question # 7 and assign scores as follows:

<table>
<thead>
<tr>
<th>Response</th>
<th>Component 6 score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not during the past month</td>
<td>0</td>
</tr>
<tr>
<td>Less than once a week</td>
<td>1</td>
</tr>
<tr>
<td>Once or twice a week</td>
<td>2</td>
</tr>
<tr>
<td>Three or more times a week</td>
<td>3</td>
</tr>
</tbody>
</table>

Component 6 score: _________
### Component 7: Daytime Dysfunction

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

<table>
<thead>
<tr>
<th>Response</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never</td>
<td>0</td>
</tr>
<tr>
<td>Once or twice</td>
<td>1</td>
</tr>
<tr>
<td>Once or twice each week</td>
<td>2</td>
</tr>
<tr>
<td>Three or more times each week</td>
<td>3</td>
</tr>
</tbody>
</table>

Question #8 score: __________

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

<table>
<thead>
<tr>
<th>Response</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>No problem at all</td>
<td>0</td>
</tr>
<tr>
<td>Only a very slight problem</td>
<td>1</td>
</tr>
<tr>
<td>Somewhat of a problem</td>
<td>2</td>
</tr>
<tr>
<td>A very big problem</td>
<td>3</td>
</tr>
</tbody>
</table>

Question #9 score: __________

3. Add the scores for question #8 and #9:

Sum of #8 and #9: ______

4. Assign component 7 score as follows:

<table>
<thead>
<tr>
<th>Sum of #8 and #9</th>
<th>Component 7 score</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>1-2</td>
<td>1</td>
</tr>
<tr>
<td>3-4</td>
<td>2</td>
</tr>
<tr>
<td>5-6</td>
<td>3</td>
</tr>
</tbody>
</table>

Component 7 score: ______

### Global PSQI Score

Add the seven component scores together:

Global PSQI Score: ______
Stanford Sleepiness Scale

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

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

<table>
<thead>
<tr>
<th>Degree of Sleepiness</th>
<th>Scale Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Feeling active, vital, alert, or wide awake</td>
<td>1</td>
</tr>
<tr>
<td>Functioning at high levels, but not at peak; able to concentrate</td>
<td>2</td>
</tr>
<tr>
<td>Awake, but relaxed; responsive but not fully alert</td>
<td>3</td>
</tr>
<tr>
<td>Somewhat foggy, let down</td>
<td>4</td>
</tr>
<tr>
<td>Foggy; losing interest in remaining awake; slowed down</td>
<td>5</td>
</tr>
<tr>
<td>Sleepy, woozy, fighting sleep; prefer to lie down</td>
<td>6</td>
</tr>
<tr>
<td>No longer fighting sleep, sleep onset soon; having dream-like thoughts</td>
<td>7</td>
</tr>
<tr>
<td>Asleep</td>
<td>X</td>
</tr>
</tbody>
</table>
M. Functional Outcomes of Sleep Questionnaire

Relevant Questions:

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

FOSQ questions are answered using numbers from 0-4.

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

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

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

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

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

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

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

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

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

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

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

Q11 - Do you have difficulty visiting with your family or friends in your home because you become sleepy or tired?

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

Q13 - Do you have difficulty doing things for your family or friends because you are too sleepy or tired?

Q14 - For question 15 answer using only 1, 2, 3 or 4. Has your relationship with family, friends or work colleagues been affected because you are sleepy or tired?

Q15 - Do you have difficulty exercising or participating in a sporting activity because you are too sleepy or tired?
Q17 - Do you have difficulty watching movie or videotape because you become sleepy or tired?

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

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

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

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

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

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

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

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

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

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

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

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

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

Quick Links to

Population-Based Studies
Questions from Large-Sample Sleep Studies
Questions From Sleep Scales and Questionnaires
I-A. American Time Use Survey Questionnaire

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

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:
Module 3: Quality of Life and Care Giving—Page 42
Module 7: Asthma History—Page 54

Behavioral Risk Factor Questionnaire, 2002:
Pages 68–69

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

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


I-D. Fatality Analysis Reporting System

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

Query: Create a Query

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


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


Section 4. History of Asthma (Symptoms & Episodes):
Page 12


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

Questionnaire: http://www.hcp.med.harvard.edu/ncs/ftpdir/Baseline%20NCS.pdf

I-I. National Health Interview Survey, 2002

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

Family Questionnaire:
Page 38

Module: Adult Core Questionnaire
Section: Conditions
Page 7
Module: Child Core Questionnaire
Section: Part B, Mental Health
Page 11

2002 Variable Supplement: Alternative Medicine
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
Questionnaire:

Homepage: http://www.cdc.gov/nchs/about/major/slaits/nsch.htm
Questionnaire: http://www.cdc.gov/nchs/data/slaits/NSCH_Questionnaire.pdf
Page 39 of 65

I-N. National Survey of Early Childhood Health
Homepage: http://www.cdc.gov/nchs/about/major/slaits/nsech.htm
Questionnaire: http://www.cdc.gov/nchs/data/slaits/survey_sech00.pdf
Section 3: Interactions with Health Care Providers
A3Q03 (13A-c)—Page 58, A3Q03_A (13A-c-iii)—Page 59, A3Q14 (13B-c)—Page 62,
A3Q14_A (13B-c-iii)—Page 62

Guide to Selected Publicly Available Sleep-Related Data Resources—July 2006
I-O. Nurses’ Health Study

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

2001 Questionnaire:
Questions 12, 13, 15 on page 2 of Questionnaire, and Question 42 on page 5 of Questionnaire

2002 Questionnaire:
Questions 2 and 3 on page 1 of Questionnaire

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


Questionnaire:


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

Time Use Questionnaire: http://www.bls.gov/nls/quex/y97r3timeuse.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:
Pages 49 to 52

I-V. Sleep Heart Health Study (SHHS)

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


Framingham:

New York:

ARIC, CHS, Tucson/Strong Heart:

Sleep Data—Quality Assessment and Preliminary Report:

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
(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
(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
(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:
Relevant Pages: 4, 13, 16, 20, 31
II-E. Older Adults and Arthritis

Pub-Med Abstract
(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
(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
(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
Sleep Apnea Questionnaire  http://www.apneanet.org/question.htm

III-B. Epworth Sleepiness Scale

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
(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
(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
(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


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

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

III-K. Pittsburgh Sleep Quality Index

Pub-Med Abstract

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


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