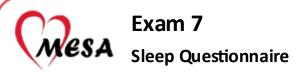


Exam 7 Sleep Ouestionnaire

Participant ID#:					Acrostic:				
Technician ID:				ate:	Month /		/	Vo	

Questionnaire Day The following questions are about your sleep. Please consider both what others have told you about your sleep and what you know yourself. 1. How much sleep do you usually get each night (or over the longest time you are in bed)? hours minutes 2. Have you had problems falling asleep, staying asleep, or waking up too early that occurred three or more times per week and lasted 3 or months? O Yes a. If yes, when did these problems first start? O No O In the last year O Between one and 5 years ago O Between 5 and 10 years ago O More than 10 years ago b Do you currently have problems with falling asleep, staying asleep, or waking too early? O Yes O No

- 3. Overall, how was your typical night's sleep during the past 4 weeks?
 - O Very sound or restful
 - O Sound and restful
 - O Average quality
 - O Restless
 - O Very Restless
- 4. Do you feel your sleep has changed over the past five years?
 - O Definitely much worse
 - O Somewhat worse
 - O A little worse
 - O About the same
 - O Somewhat better
 - O Definitely much better



5. Ove	r the past 4 weeks , how often have you snor	ed?							
0	Never								
0	Rarely (1-2 nights a week)								
0	Sometimes (3-5 nights a week)								
0	Always or almost always (6-7 nights a week)								
0	Don't know								
6. Ove	r the past 4 weeks , how often have you had	times when you stopped breathing during your sleep?							
0	Never								
0	Rarely (1-2 nights a week)								
0	Sometimes (3-5 nights a week)								
0	Always or almost always (6-7 nights a week)								
0	Don't know								
7. Do y	you ever experience a desire to move your le	gs because of discomfort or disagreeable sensations in your legs?							
0	Yes —	a. Do you sometimes feel the need to move to relieve the discomfort, for							
0	No	example by walking, or by rubbing your legs?							
0	Don't know	O Yes							
		O No							
		O Don't know							
		b. Are these symptoms worse when you are at rest, with at least temporary relief by activity?							
		O Yes							
		O No							
		O Don't know							
		c. Are these symptoms worse later in the day or at night?							
		O Yes							
		O No							
		O Don't know							
8. Hov	v likely are you to doze off or fall asleep durir	ng the daytime when you don't mean to?							
		the time							

0

0

0

0

	more alert in the mornings and consider themselves to be selves to be evening people. What do you consider yourself			ers are most alert in the even ings						
O Definitely a morning person										
O More a morning than an evening person										
O More an eve	More an evening than a morning person									
O Definitely an evening person										
O Neither a "morning" nor an "evening" type										
	tions ask about diagnosed sleep disorders. by a doctor or other health care provider that you have an	y of the	e following:							
10. Sleep apnea (or	obstructive sleep apnea, OSA)? O Yes O No									
	If yes: Do you use any of the following for your sleep ap			If yes: About how many nights a week						
		Yes	No	do you use this?						
	A pressure machine such as CPAP, APAP, or BiLevel?	0	0							
	A dental device during sleep (a device put in your mouth at night that moves the jaws open)?	0	0							
	Oxygen during sleep?	0	0							
11. Insomnia?	O _{Yes} O _{No}									
	If yes: Do you use any of the following for your insomnia		If yes: About how many nights a week							
		Yes	No	do you use this?						
	Over the counter medications?	0	0							
	Prescription sleeping pills (such as trazadone, Ambien)?	0	0							
12. Restless legs?	○ _{Yes} ○ _{No}	_								

13. Which of the following best describes yo	our usual work s	chedule?							
O Day shift									
O Afternoon shift									
O Night shift									
O Split shift									
O Irregular shift / On-call									
O Rotating shifts									
O Don't work									
The following questions ask about feeling sleepy or alert during the day.									
n the last 7 days									
	Not at all	A little bit	Somewhat	Quite a bit	Very much				
14. I had a hard time getting things done because I was sleepy.	0	0	0	0	0				
15. I felt alert when I woke up.	0	0	0	0	0				
16. I felt tired.	0	0	0	\circ	0				
17. I had problems during the day because of poor sleep.	0	0	0	0	0				
18. I had a hard time concentrating because of poor sleep.	0	0	0	0	0				
19. Questionnaire completed by:ParticipantProxy									