FOR OFFICE USE ONLY **Keyfield: .005**

Date:_____ **Family** ____ ____ ___ **Person** ____ ____ ____ _____ **Source:** _____

Relative: 0) **Index** 1) **Mother** 2) **Father** 3) **Daughter** 4) **Son** 5) **Brother**
6) **Sister** 7) **Spouse** 8) **Extended family** _____ 9) **Other** _____

Motherid _____ **Fatherid**_____ **Monotwin**_____ **Household**_____

ADULT CHILD LAB/GCRC VISIT TYPE 5

CASE WESTERN RESERVE HEALTH AND SLEEP STUDY

We are interested in finding out how you and your family have been doing since we last contacted you. Please answer the following questions as frankly and as accurately as possible. All information will be kept strictly confidential and used for medical or research purposes only. Although some questions may have been asked before, it is helpful for us to re-check on certain key information.

IF ANSWERING QUESTIONS FOR YOUR CHILD, GRANDCHILD, OR PERSON NEEDING ASSISTANCE PLEASE ANSWER THE QUESTIONS IN REFERENCE TO HIS OR HER HEALTH OR HISTORY.

Name _____
First Middle Last

Address_____

_____
City State Zip

E-Mail Address: _____

Telephone _____

Social Security # **{SSN}**: _____
(Required by University to issue payment.)

Date of Birth **{Birthdat}** _____
Month Date Year

Sex {Sex}: ☐1) Male
☐2) Female

Are you…? ☐1) Hispanic or Latino
(Please check one) ☐2) Not Hispanic or Latino

Race {Race}: *(PLEASE CHECK ALL THAT APPLY.)*
☐1) American Indian or Alaska Native
☐2) Asian
☐3) Black or African American
☐4) Native Hawaiian or Other Pacific
☐5) White

Marital Status {MarStat}:
☐1) Married (or common law)
☐2) Single
☐3) Separated/Divorced
☐4) Widow(er)

The following questions refer to your behavior while sleeping or trying to sleep. **Please check one response for each question.**

During the **LAST MONTH**, have you had, or have been told you do the following WHILE ASLEEP OR TRYING TO SLEEP?

	(0) **Never**	(1) **Rarely** (has occurred but less than once a week)	(2) **Sometimes** (1-2 times) per week)	(3) **Frequently** (3-4 times per week)	(4) **Always or Almost Always** (5-7 times per week)	(-2) **Don't Know**
4. Snore **{Loudsnor}**	☐	☐	☐	☐	☐	☐
5. Snort or gasp **{Snort}**	☐	☐	☐	☐	☐	☐
6. Toss, turn or thrash frequently over the night **{Toss}**	☐	☐	☐	☐	☐	☐
7. Stop breathing **{Brstops}**	☐	☐	☐	☐	☐	☐
8. Choke **{Choke}**	☐	☐	☐	☐	☐	☐
9. Struggle for breath **{Struggle}**	☐	☐	☐	☐	☐	☐
10. Wheeze or whistle (from your chest) **{Chestwhe}**	☐	☐	☐	☐	☐	☐
11. Stuffy nose **{Stuffnos}**	☐	☐	☐	☐	☐	☐
12. Chest pain while in bed **{Chstpain}**	☐	☐	☐	☐	☐	☐
13. Breathing difficulty **{Disbrth}**	☐	☐	☐	☐	☐	☐
14. Palpitations or heart Racing **{Palp}**	☐	☐	☐	☐	☐	☐
15. Jumpy or jerky legs **{Legjerk}**	☐	☐	☐	☐	☐	☐
16. Leg cramps **{DISCRAMP}**	☐	☐	☐	☐	☐	☐

Over the **LAST MONTH**, have you experienced the following? (Check frequency):

	(0) Never	**(1) Rarely** (has occurred but less than once a week)	**(2) Sometimes** (1-2 times) per week)	**(3) Frequently** (3-4 times per week)	**(4) Always or Almost Always** (5-7 times per week)	**(-2) Don't Know**
17. Difficulty falling asleep **{Diffslp}**	☐	☐	☐	☐	☐	☐
18. Frequent awakenings after falling asleep **{Freqawk}**	☐	☐	☐	☐	☐	☐
19. Excessive (too much) sleepiness during the day **{Excslpdy}**	☐	☐	☐	☐	☐	☐
20. Morning headaches **{Mornhead}**	☐	☐	☐	☐	☐	☐
21. Sleepiness that interferes with your concentration **{Concent}**	☐	☐	☐	☐	☐	☐
22. Awake feeling paralyzed, unable to move for short periods **{Paralyze}**	☐	☐	☐	☐	☐	☐
23. Lying awake during your sleep time feeling worried, depressed, or sad **{Deprslp}**	☐	☐	☐	☐	☐	☐
24. Pain or physical discomfort **{Dispain}**	☐	☐	☐	☐	☐	☐
25. Feeling tired or fatigued after you sleep **{Fatigue}**	☐	☐	☐	☐	☐	☐
26. Heartburn during your sleep time **{Dishrtb}**	☐	☐	☐	☐	☐	☐

Over the **LAST MONTH**, have you experienced the following? (Check frequency):

	(0) Never	**(1) Rarely** (has occurred but less than once a week)	**(2) Sometimes** (1-2 times) per week)	**(3) Frequently** (3-4 times per week)	**(4) Always or Almost Always** (5-7 times per week)	**(-2) Don't Know**
27. Used coffee, tea, or other caffeine drinks to stay awake during your normal waking time **{Caffdrk}**	☐	☐	☐	☐	☐	☐
28. Had to pull off the road while driving or almost had been in a car accident due to sleepiness **{Offroad}**	☐	☐	☐	☐	☐	☐
29. Almost had/been in a car accident because of sleepiness **{slpcrash}**	☐	☐	☐	☐	☐	☐
30. Were told by a relative or friend that you were too sleepy **{toldslp}**	☐	☐	☐	☐	☐	☐
31. No matter how much sleep you had, you didn't wake up feeling rested **{slprest}**	☐	☐	☐	☐	☐	☐
32. Needed to wake up from sleep to use the toilet 2 or more times **{upbath}**	☐	☐	☐	☐	☐	☐
33. Your bedtime changed by two or more hours **{chgtime}**	☐	☐	☐	☐	☐	☐
34. Headaches during your sleep time **{dishead}**	☐	☐	☐	☐	☐	☐
35. Loud Snoring – loud enough to wake others **{snloudly}**	☐	☐	☐	☐	☐	☐

36. What position do you usually sleep **{posn}**?

☐ My back (1) ☐ My side (2) ☐ My stomach (3)
☐ My back and side (4) ☐ All positions (5) ☐ Sitting Up (6)
☐ Not sure (-2)

37. Have you ever been told that you snore **{anysnore}**?

☐ No (0)
☐ Yes (1)
☐ Not Sure (-2)

IF YES:

During the **ENTIRE TIME** you have snored, has your snoring usually been **{timesnor}**:

□Only slightly louder than heaving breathing (1)
□About as loud as mumbling or talking (2)
□Louder than talking (3)
□Extremely loud - can be heard through a closed door (4)
□Not sure (-2)

Over the **LAST ONE MONTH**, has your snoring usually been **{monsnor}**:

□Only slightly louder than heaving breathing (1)
□About as loud as mumbling or talking (2)
□Louder than talking (3)
□Extremely loud - can be heard through a closed door (4)
□I haven't snored in the last month (5)
□Not sure (-2)

Over the **LAST ONE MONTH**, when you have snored, has the snoring sounded **{samesnor}**:

□The same with each breath (snore) (1)
□Sometimes loud, sometimes soft (2)
□I haven't snored in the last month (3)
□Not sure (-2)

Has your snoring **EVER** been so loud that it has disturbed others **{distsnor}**?

□ NO (0)
□ YES (1)
□ NOT SURE (-2)

IF YES:

Over the **LAST MONTH**, has your snoring disturbed others **{mondist}**?

□ NO (0) □ YES (1) □ NOT SURE (-2)

Based on what others have told you, how many years do you think your snoring has been that loud (loud enough to disturb others) **{yeardist}**?

_____ Years or □ NOT SURE (-2)

38. Have you EVER worked outside the home **{work}**?
☐ NO (0)
☐ YES (1)

IF YES:

Have you EVER fallen asleep on the job **{workslp}**?
☐ NO (0)
☐ YES (1)

IF YES, has this occurred **{workslno}**:
☐ Only once (1) ☐ 2-5 times (2) ☐ 6-20 times (3)
☐ 21-100 times (4) ☐ More than 100 times(5) ☐ Not sure (-2)

Have you EVER been involved in an accident at work that has required you to see a nurse or doctor? **{workacc}**
☐ NO (0)
☐ YES (1)
☐ NOT SURE (-2)

IF YES, has this occurred **{wkaccno}**:
☐ Only once (1) ☐ 2-5 times(2) ☐ 6-20 times (3)
☐ 21-100 times (4) ☐ More than 100 times (5) ☐ Not sure (-2)

39. Have you EVER operated a motor vehicle **{drive}**?
☐ NO (0)
☐ YES (1)

IF YES:

How many years have you been driving {yrsdvr}? _____

Have you ever fallen asleep while you were behind the wheel {drvrslp}?
☐ No (0) ☐ Yes (1) ☐ Not Sure (–2)

IF YES, has this occurred **{modvrslp}**:

☐ Only once (1) ☐ 2-5 times (2) ☐ 6-20 times (3)
☐ 21-100 times (4) ☐ More than 100 times (5) ☐ Not sure (-2)

39a. How many 'near miss' car accidents have you had due to sleepiness **{nmcaracc}**? _____

39b. How many car accidents have you ever had while driving a car **{car}**? _____

39c. How many car accidents occurred because you felt sleepy or fell asleep behind the wheel of a car **{carslpy}**?_____

40. During the **PAST MONTH**, have you fallen asleep while talking face to face with someone **{talking}**?

☐ NO (0)
☐ YES (1)
☐ NOT SURE (-2)

IF YES:
Has this occurred **{talkno}**:

☐ Only once (1) ☐ 2-5 times (2) ☐ 6-20 times (3)
☐ 21-100 times (4) ☐ More than 100 times (5) ☐ Not Sure (-2)

41. During the **PAST MONTH,** have you fallen asleep while talking on the telephone **{talkphon}**?

☐ NO (0)
☐ YES (1)
☐ NOT SURE (-2)

IF YES:
Has this occurred **{tkphnno}**:

☐ Only once (1) ☐ 2-5 times (2) ☐ 6-20 times (3)
☐ 21-100 times (4) ☐ More than 100 times (5) ☐ Not Sure (-2)

42. During the **PAST MONTH**, have you had to take daytime naps of 5 minutes or longer **{naps}**?

☐ NO (0)
☐ YES (1)
☐ NOT SURE (-2)

IF YES:

Has this occurred **{nonaps}**?

☐ Only once (1) ☐ 2-5 times (2) ☐ 6-20 times (3)
☐ 21-100 times (4) ☐ More than 100 times (5) ☐ Not Sure (-2)

On average, how long are your naps (in minutes) **{longnaps}**?
_____ minutes (example 1-1/2 hrs. = 90 minutes)

How often do you feel refreshed after napping **{feelnap}**?

☐ Never (0) ☐ Rarely (1) ☐ Sometimes (2)
☐ Usually (3) ☐ Always (4) ☐ Not Sure (-2)

43. During the **PAST MONTH**, what **TIME** (on average):
Have you **gone to bed**? Weekdays **{daybed}**:____:_____ a.m. or p.m. (please circle)
(First closed eyes in attempt to fall asleep does not mean fallen asleep) Weekends **{endbed}**:____:_____ a.m. or p.m. (please circle)
EXAMPLE: (10:00 a.m. or p.m.)

43a. How long does it usually take you to **fall asleep**?
Minutes: _____
Hours: _____

43b. What time do you **wake up** from your usual sleep?
Weekdays **{daywake}**:____:_____ a.m. or p.m. (please circle)
Weekends **{endwake}**:____:_____ a.m. or p.m. (please circle)
EXAMPLE: (8:00 a.m. or p.m.)

44. How much sleep do you usually get on:
Weekdays: _____ Hours **{dayhrs}** _____Minutes **{daymin}**
Weekends: _____ Hours **{endhrs}** _____Minutes **{endmin}**

45. How many total hours of actual sleep do you get in a 24-hour period (including naps) **{tothrslp}**?

- ☐ 5 hours or less (0)
- ☐ 6 hours - 6.9 hours (1)
- ☐ 7 hours - 7.9 hours (2)
- ☐ 8 hours - 8.9 hours (3)
- ☐ 9 hours - 9.9 hours (4)
- ☐ 10 hours - 10.9 hours (5)
- ☐ 11+ hours (6)

46. During the **PAST MONTH**, how many times **per night** do you wake up **{nightup}**?

- ☐ Never (0)
- ☐ 1-2 Times (1)
- ☐ 3-5 Times (2)
- ☐ More than 5 times (3)

Reason **{upreas}**: _____ Not Sure why ☐ (-2)

47. Do you function best in the **{function}**:

☐ Morning (1) ☐ Afternoon (2) ☐ Evening (3)
☐ No best time (4) ☐ Don't Know (-2)

48. Do you function worst in the **{dysfn}**:

☐ Morning (1) ☐ Afternoon (2) ☐ Evening (3)
☐ No best time (4) ☐ Don't Know (-2)

49. During the **PAST MONTH**, how long did it usually take you to "get going" (become fully alert and functional) after your usual sleep time **{going}**?

- ☐ Less than 5 minutes (1)
- ☐ 5-15 Minutes (2)
- ☐ 15-30 Minutes (3)
- ☐ More than 30 Minutes (4)
- ☐ Not Sure (-2)

50. Over the **last month**, how often have you fallen asleep while: (please check appropriate box)

	(0) Never	(1) Has occurred, but less than once a week	(2) Sometimes (1 to 2 times per week)	(3) Frequently (Three to four times per week)	(4) Always or Almost Always (5 to 7 times per week	(-2) Not Sure
While watching television **{tv}**?						
While reading or studying **{read}**?						
While eating **{eat}**?						
While at work or school **{wkschool}**?						
While playing or active with your friends **{actplay}**?						

51. During the **PAST YEAR**, have you been troubled by shortness of breath when hurrying on level ground or walking up a slight hill **{shbrwal}**?
☐ NO (0)
☐ YES (1)
☐ NOT SURE (-2)

IF YES:

Has this occurred during the past month **{shbrmon}**?
☐ NO (0)
☐ YES (1)
☐ NOT SURE (-2)

52. What is your normal walking pace outdoors **{walkpace}**?
☐ Slow (less than 2 mph) (0)
☐ Normal, average (2 to 2.9 mph) (1)
☐ Brisk (3 to 3.9 mph) (2)
☐ Very brisk, striding (4 mph or faster) (3)
☐ Unable to walk (4)

53. How many flights of stairs (not steps) do you climb daily **{nostairs}**?
☐ No flights (0)
☐ 1-2 flights (1)
☐ 3-4 flights (2)
☐ 5-9 flights (3)
☐ 10-14 flights (4)
☐ 15 or more flights (5)

54. During the **PAST 5 YEARS,** what is the difference between your highest and lowest weight (excluding illness) **{diffwgt}**? _____
☐ Gained **{wgtgain}**? ☐ Lost **{wgtlost}**?

55. Were you born prematurely (more than 2 weeks early) **{bornpre}**?
☐ No (0) ☐ Yes (1) ☐ Not Sure (-2)

IF YES:

Approximately how many weeks early were you born **{weekpre}**?
Weeks_____ Not Sure ☐

56. Did you require oxygen after birth **{rego2}**?
☐ No (0) ☐ Yes (1) ☐ Not Sure (-2)

IF YES:

How long did you require oxygen **{longo2}**?
☐ 1 day or less (1) ☐ 2 to 3 days (2)
☐ 4 to 6 days (3) ☐ 7 to 13 days (4)
☐ 14 to 28 days (5) ☐ More than 29 days (6)
☐ Not sure (-2)

57. Were you hospitalized in an intensive care unit after you were born **{nicu}**?

☐ No (0) ☐ Yes (1) ☐ Not Sure (-2)

If Yes:

For how long **{longicu}**?

☐ 1 day or less (1)
☐ 2 to 3 days (2)
☐ 4 to 6 days (3)
☐ 7 to 13 days (4)
☐ 14 to 28 days (5)
☐ More than 29 days (6)
☐ Not sure (-2)

58. How much did you weigh at birth **{birthwgt}**?

☐ Less than 2 lbs. (1)
☐ 2 lbs. – 3.9 lbs. (2)
☐ 4 lbs. – 4.9 lbs. (3)
☐ 5 lbs. – 5.9 lbs. (4)
☐ 6 lbs. – 6.9 lbs. (5)
☐ 7 lbs. – 8.9 lbs. (6)
☐ Greater than 9 lbs. (7)
☐ Not Sure (-2)

59. Did your mother smoke while she was pregnant with you **{momsmoke}**?

☐ No (0) ☐ Yes, at least one cigarette a day (1) ☐ Not Sure (-2)

60. Did your mother smoke during the first five years of your life **{smoke5yr}**?

☐ No (0) ☐ Yes, at least one cigarette a day (1) ☐ Not Sure (-2)

61.

		TOTAL TIME PER WEEK									
DURING THE PAST YEAR, what was your average time **PER WEEK** spent doing each of the following recreational activities?		Zero (0)	1-4 Min (1)	5-19 Min. (2)	20-59 Min. (3)	One Hour (4)	1-1.5 Hrs. (5)	2-3 Hrs. (6)	4-6 Hrs. (7)	7-10 Hrs. (8)	11+ Hrs. (9)
Walking for exercise or walking to work **{walkexer}**											
Jogging (slower than 10 minutes/mile) **{jogexer}**											
Running (10 minutes/mile or faster) **{runexer}**											
Bicycling (include stationary machine) **{bicexer}**											
Tennis, squash, racquetball **{tenexer}**											
Lap swimming **{swimexer}**											
Other aerobic exercise (aerobic dance, ski or stair machine, etc.) **{othexer}**											
Lower intensity exercise (yoga, stretching, toning) **{lowexer}**											
Other vigorous activities (e.g., lawn mowing) **{vigexer}**											
Weight training of resistance exercises (Include free weights or machines such as Nautilus)	Arm weights **{armexer}**										
	Leg weights **{legexer}**										

62. During the **PAST YEAR**, has your chest ever made whistling noises or sounded wheezy **{cheswhe}?**

☐ NO (0) ☐ YES (1) ☐ NOT SURE (-2)

IF YES:

Has this occurred:

When you had a cold **{whecold}**?	☐No	☐Yes	☐Not Sure
Occasionally apart from colds **{apacold}**?	☐No	☐Yes	☐Not Sure
Most days or nights **{daynite}**?	☐No	☐Yes	☐Not Sure
When you are exercising **{wheexer}**?	☐ No	☐Yes	☐Not sure
When exposed to dust or fumes **{dustfume}**?	☐No	☐Yes	☐Not sure
When exposed to pollens **{pollens}**?	☐No	☐Yes	☐Not sure
During the night **{onlynite}**?	☐No	☐Yes	☐Not sure
During the past month **{pastmon}**?	☐No	☐Yes	☐Not sure
When breathing cold air **{coldair}**?	☐ No	☐Yes	☐Not sure

63. Have you ever had an attack of wheezing during the past year that made you feel short of breath **{wheattac}**?

☐ No ☐ Yes ☐ Not Sure

64. If you had any colds this year did they go to your chest **{chescold}**?

☐ No ☐ Yes ☐ Not Sure

65. Are you bothered by a stuffy or runny nose **{strnnos}**?

☐ No ☐ Yes ☐ Not Sure

66. Do the following situations cause you to have a stuffy or runny nose?

A smoky room **{rmsmoky}**?	☐ No	☐ Yes	☐ Not Sure
A dusty room **{rmdusty}**?	☐ No	☐ Yes	☐ Not Sure
Cold weather **{weatcold}**?	☐ No	☐ Yes	☐ Not Sure
Exercise **{stufexer}**?	☐ No	☐ Yes	☐ Not Sure

DURING THE PAST YEAR:

67. Did you usually have a cough **{cough}**?
☐ No ☐ Yes ☐ Not Sure

68. Did you usually cough on most days for three (3) consecutive months or more during the year **{chrcough}**?
☐ No ☐ Yes ☐ Not Sure

69. Did you usually bring up phlegm from your chest **{phlegm}**?
☐ No ☐ Yes ☐ Not Sure

IF YES:
Did you usually bring up phlegm like this as much as twice a day? (Four or more times a week?) **{chrphle}**
☐ No ☐ Yes ☐ Not Sure

70. Did you usually bring up phlegm at all on getting up or first thing in the morning **{phl1st}**?
☐ No ☐ Yes ☐ Not Sure

71. Did you bring up phlegm at all during the rest of the day or night **{phlrest}**?
☐ No ☐ Yes ☐ Not Sure

IF YES:
Did you usually bring up phlegm like this for three consecutive months or more during the year **{phl3}**?
☐ No ☐ Yes ☐ Not Sure

72. Have you had periods or episodes of increased cough and phlegm lasting three weeks or more **{couphl3}**?
☐ No ☐ Yes ☐ Not Sure

73. In the last year have you ever taken the following?

Blood Pressure Medicine **{bpmedyr}**	☐No ☐Yes	**If yes, have you taken any medicine in the last 3 days {bpmed3dy}? ☐No ☐Yes**
Breathing Pills **{asthplyr}**	☐No ☐Yes	**If yes, have you taken any medicine in the last 3 days {astpl3dy}? ☐No ☐Yes**
Breathing Sprays **{asthspyr}**	☐No ☐Yes	**If yes, have you taken any medicine in the last 3 days {astsp3dy}? ☐No ☐Yes**
Heart Pills **{hrtplyr}**	☐No ☐Yes	**If yes, have you taken any medicine in the last 3 days {hrtpl3dy}? ☐No ☐Yes**
Water Pills **{h2opilyr}**	☐No ☐Yes	**If yes, have you taken any medicine in the last 3 days {h2opl3dy}? ☐No ☐Yes**
Sleeping Pills **{slppilyr}**	☐No ☐Yes	**If yes, have you taken any medicine in the last 3 days {slppl3dy}? ☐No ☐Yes**
Antihistamines and/or Decongestants **{nasdecyr}**	☐No ☐Yes	**If yes, have you taken any medicine in the last 3 days {nasdc3dy}? ☐No ☐Yes**
Thyroid Medicine **{thyrmdyr}**	☐No ☐Yes	**If yes, have you taken any medicine in the last 3 days {thyrm3dy}? ☐No ☐Yes**
Tranquilizers (e.g.Valium, Zantac) **{tranquyr}**	☐No ☐Yes	**If yes, have you taken any medicine in the last 3 days {tranq3dy}? ☐No ☐Yes**
Progesterone, Hormones, or birth control pills **{progyr}**	☐No ☐Yes	**If yes, have you taken any medicine in the last 3 days {prog3dy}? ☐No ☐Yes**
Stimulants (e.g. Ritalin, Adderal) **{stimyr}**	☐No ☐Yes	**If yes, have you taken any medicine in the last 3 days {stim3dy}? ☐No ☐Yes**

74. **Regular medicine:**

In the last three days have you taken ***Acetaminophen*** (e.g. Tylenol) **{acetamin}**? ☐ NO ☐ YES

OVER LAST MONTH {acetamon}?

☐ NO

☐ YES→**HOW MANY DAYS PER WEEK DO YOU TAKE IT{acetaday} ?**

☐ Every now and then (not regularly) (1)
☐ 2-3 days per week (2)
☐ 4-5 days per week (3)
☐ 6-7 days per week (4)

→*On **average***, how many tablets did you take **{acetamno}**? _____

In the last three days have you taken **'Baby' or low dose aspirin {babyaspr}?** ☐ NO ☐ YES

OVER LAST MONTH {babyamon}?

☐ NO

☐ YES→**HOW MANY DAYS PER WEEK DO YOU TAKE IT{babyaday} ?**

☐ Every now and then (not regularly) (1)
☐ 2-3 days per week (2)
☐ 4-5 days per week (3)
☐ 6-7 days per week (4)

→*On **average***, how many tablets did you take **{babyasno}**? _____

In the last three days have you taken ***Aspirin or aspirin-containing products (325 mg/tablet or more)*** **{aspirin}*?*** ☐ NO ☐ YES

OVER LAST MONTH {aspirmon}?

☐ NO

☐ YES→**HOW MANY DAYS PER WEEK DO YOU TAKE IT{aspirday} ?**

☐ Every now and then (not regularly) (1)
☐ 2-3 days per week (2)
☐ 4-5 days per week (3)
☐ 6-7 days per week (4)

→*On **average***, how many tablets did you take **{asprinno}**? _____

In the last three days have you taken ***Ibuprofen (e.g. Advil, Motrin, Nuprin)*** **{ibuprofe}*?*** ☐ NO ☐ YES

OVER LAST MONTH {ibuprmon}?

☐ NO

☐ YES→**HOW MANY DAYS PER WEEK DO YOU TAKE IT{ibuprday} ?**

☐ Every now and then (not regularly) (1)
☐ 2-3 days per week (2)
☐ 4-5 days per week (3)
☐ 6-7 days per week (4)

→*On **average***, how many tablets did you take **{ibuprono}**? _____

74b. Regular medicine: Mark if used in the **last three days.**

Anti-inflammatory analgesics, 2+ times/week **{antiinfl}** (e.g. Motrin, Aleve, Naprosyn, Relafen, Ketoprofen, Anaprox)	☐No	☐Yes
Celebrex or Vioxx (COX-2-inhibitors) **{celeviox}**	☐No	☐Yes
Thiazide diuretic (Hydrocholorthiazide) **{thiazide}**	☐No	☐Yes
Lasix (Furosemide) **{lasix}**	☐No	☐Yes
Calcium blocker (e.g. Calan, Procardia, Cardizem) **{calcbloc}**	☐No	☐Yes
Beta-blocker (e.g. Inderal, Lopressor, Tenormin, Corgard, Diltiazem, Atenonal, Propranolol,) **{betbloc}**	☐No	☐Yes

ACE Inhibitors (Capoten, Vasotec, Zestril, Captopril, Lisonopril) **{aceinhib}** ☐No ☐Yes
Other antihypertensive (e.g. Aldomet, Apresoline) **{antihype}** ☐No ☐Yes
Steroids taken orally (e.g. Prednisone, Decadron, Medrol) **{oralster}** ☐No ☐Yes
Inhaled steroids (Azmacort, Flucinonide) **{insteroi}** ☐No ☐Yes
Inhaled bronchodilator (Alupent, Albuterol, Ventolin) **{inbronch}** ☐No ☐Yes
Digoxin (Digitalis) **{digoxin}** ☐No ☐Yes
Antiarrhythmic(e.g. Pronestyl, Quinidine, Norpace) **{antiarrh}** ☐No ☐Yes
Coumadin (blood thinner) **{blodthin}** ☐No ☐Yes
Cholesterol lowering drugs [e.g. Mevacor (lovastatin), Pravachol (pravastatin), Zocor (simvastatin), Lipitor] **{chollowd}**
☐No ☐Yes

IF YES: Number of years used cholesterol lowering drugs {cholyrs}:
☐ 0-2 yrs. ☐ 3-5 yrs. ☐ 6+ years

Other cholesterol lowering drug (Gemfibrozil) **{othchldr}** ☐No ☐Yes
Cimetidine (Tagamet) **{cimetidi}** ☐No ☐Yes
Other H2 Blocker (e.g. Zantac, Pepcid, Ranitidine) **{h2bloc}** ☐No ☐Yes
Acid Reflex (Prilosec or Prevacid) **{prilprev}** ☐No ☐Yes
Insulin (Diabetes) **{insulin}** ☐No ☐Yes
Oral Hypoglycemic (Glyburide, Glucophage) **{oralgluc}** ☐No ☐Yes
Anti depressant **{antidepr}** ☐No ☐Yes
Prozac **{prozac}** ☐No ☐Yes
Zoloft **{Zoloft}** ☐No ☐Yes
Paxil **{paxil}** ☐No ☐Yes
Celexa **{celexa}** ☐No ☐Yes
Other antidepressants (e.g. Elavil, Tofranil, Pamelor) **{othantid}** ☐No ☐Yes
Tranquilizers(Valium, Zanax, Ativan, Librium, Buspar, Buspirone) **{tquilize}** ☐No ☐Yes
Meridia (sibutramine) **{meridia}** ☐No ☐Yes
Phentermine **{phenterm}** ☐No ☐Yes
Xenical **{xenical}** ☐No ☐Yes
Thyroid (e.g. Synthroid, Thyrogen, Levothroid) **{thryd}** ☐No ☐Yes
Dementia (Aricept) **{dementia}** ☐No ☐Yes
Sleeping Medicine (Ambien, Oxybutynin, Trazadone) **{sleepmed}** ☐No ☐Yes
Antihistamine (Benedryl) **{antihist}** ☐No ☐Yes
Nitrates (Isordil, Isorbide) **{nitrates}** ☐No ☐Yes
Nytroglycerin **{nitrogly}** ☐No ☐Yes
Theophylline (Theodor, Aminophylline) **{theophyll}** ☐No ☐Yes
Other regular medicine **{regmedot}** ☐No ☐Yes
Please specify **{othregmd}**: _____

74c. Do you currently take a multi-vitamin {multivit}?

O YES→ How many do you take per week **{nomulvit}**? ☐ 2 or less (1) ☐ 3-5 (2) ☐ 6-9 (3) ☐10 or more (4)
O NO What type of multivitamin do you take ? Mark brand name equivalent if generic is used, (e.g. *Sentury* is equivalent to *Centrum*) **Mark the ONE type used most frequently.**

o Allbee + C **{allbeec}** o Centrum, Century, Sentury **{centsent}** o One A Day Essential **{oneadaye}**
o Theragram **{theragrm}** o Calitrate 600 **{calit600}** o Centrum Silver **{centsilv}**
o One A Day Maximum **{oneadaym}** o Theragram M **{theragmm}** o CVS Daily **{cvsdaily}**
o Formula 100, Nutri-100 **{fornu100}** o One A Day Womens **{oneadayw}** o Unicap **{unicap}**
o CVS Daily w Minerals **{cvsminer}** o Health Balance Daily Pack **{healtpac}** o Protegra **{protegra}**
o Unicap-M **{unicapm}** o CVS Pro-Vite**{cvsprovi}** o CVS Mega Multi **{cvsmegml}**
o Shaklee Vita-Lea **{Shaklee}** o Unicap Senior **{unicapsr}** o VI-MIN 75 **{vimin75}**
o Nuskin Life Pack **{nuskinpk}** o Solotron for Women **{solotron}** o Stresstabs **{stresstb}**
o Central Vite **{centralv}** o Women Power Pack **{wompowpk}** o Surbex T **{surbext}**
o Ocuvite **{ocuvitpl}** o Central Vite Plus **{centvits}** o Central Vite Select **{centvits}**
o Z-Bec **{zbec}** o Ocuvite Plus **{ocuvitpl}**
o One A Day Antioxidant Plus **{onedayap}** o Healthy Direction Forward Plus **{hdforwpl}**

If your type is not listed write exact brand/type here {yourvita}. _____

Does your multivitamin include iron {youvitir}? ☐ **No** ☐ **Yes** ☐ **Not Sure**

74d. Do you take Folic Acid {folicacd}? ☐ No ☐ Yes ☐ Not Sure

Dose per day **{foldosdy}**: ☐ Less than 100 Mcg (0) ☐ 100-300 Mcg (1) ☐ 301-500 Mcg (2)
☐ 501 Mcg or more (3) ☐ Do not know (-2)

75. If you are a woman and have ever had menstrual periods, please answer the following:

At what age did your menstrual periods begin {perstart}?

☐ 9 years old or younger (1) ☐ 10 years old (2) ☐ 11 years old (3) ☐ 12 years old (4) ☐ 13 years old (5)
☐ 14 years old (6) ☐ 15 years old (7) ☐ 16 years old (8) ☐ 17 years old or older (9)

Are you currently pregnant {curpreg}? ☐ No ☐ Yes ☐ Not Sure

Have your menstrual periods stopped permanently {perstop}?

☐ No, premenopausal.
☐ Yes (Yes includes those who have reached menopause but now have periods induced by hormones.)
☐ Not Sure

IF NO: When was your last period {lstmens}?

☐ Currently menstruating (1) ☐ One month ago (5)
☐ 1 week ago (2) ☐ More than one month ago, but less than 6 months (6)
☐ 2 weeks ago (3) ☐ More than 6 months ago (7)
☐ 3 weeks ago (4)

IF YES:

At what age did your natural periods cease {agestop}? _____

For what reason did they cease {surgery}?

☐ Surgery → If due to surgery, were ovaries removed **{ovaries}**?
☐ Yes, both (1)
☐ Yes, only one (2)
☐ No, only uterus removed (3)
☐ Radiation or Chemotherapy **{radchemo}**

IF NATURAL MENOPAUSE (not due to the above), have you had subsequent surgery to remove ovaries or uterus?
(Mark all that apply)

☐ No **{natsurno}** ☐ One ovary removed **{n1ovrem}**
☐ Both Ovaries Removed **{n2ovrem}** ☐ Uterus Removed **{utergone}**

76. Have you used prescription female hormones {hormones}? (eg. birth control, hormone replacement therapy)

☐ **No** ☐ **Yes**

IF YES:

a) How many months did you use them during the last 2 years **{yrshormo}**.

☐ None (0)
☐ 1-4 months (1)
☐ 5-9 months (2)
☐ 10-14 months (3)
☐ 15-19 months (4)
☐ 20-24 months (5)

b) Mark the types of hormones you have used the longest during this period.

Estrogen	No	Yes
Oral Premarin **{premarin}**		
Patch Estrogen **{patchest}**		
Vaginal Estrogen **{vagestro}**		
Ogen **{ogen}**		
Estrace **{estrace}**		
Estratest **{estrate}**		
Other Estrogen **{othestro}** Specify: **{specest}**		

Progesterone/ Progestin	No	Yes
Provera/Cycrin/MPA **{procycmp}**		
Vaginal **{vaginal}**		
Micronized (e.g. Prometrium) **{microniz}**		
Other Progesterone **{othprog}** Specify: **{specprog}**		

COMBINED	No	Yes
Prempro (pink) **{premprop}**		
Prempro (blue) **{premprob}**		
Premphase **{premphas}**		
Combipatch **{combipat}**		
FemHRT **{femhrt}**		

Other hormones or birth control pills {othhpill}? ☐ **No** ☐ **Yes**

If yes, please specify {specprog}: _____

FAMILY HISTORY

77. Has your biological mother or biological father had any of the following?
***IF YES,* please include approximate age diagnosed by a doctor.**

	MOTHER	FATHER
SLEEP APNEA {momosa} /{dadosa}	☐ NO ☐ YES → **Age first diagnosed____ {mageosa}** (Do not know age ☐) ☐ NOT SURE	☐ NO ☐ YES → **Age first diagnosed ____ {dageosa}** (Do not know age ☐) ☐ NOT SURE
NARCOLEPSY {momnarc} / {dadnarc}	☐ NO ☐ YES → **Age first diagnosed____ {magenarc}** (Do not know age ☐) ☐ NOT SURE	☐ NO ☐ YES → **Age first diagnosed ____ {dagenarc}** (Do not know age ☐) ☐ NOT SURE
HIGH BLOOD PRESSURE {mombp} / {dadbp}	☐ NO ☐ YES → **Age first diagnosed____ {magebp}** (Do not know age ☐) ☐ NOT SURE	☐ NO ☐ YES → **Age first diagnosed ____ {dagebp}** (Do not know age ☐) ☐ NOT SURE
CONGESTIVE HEART FAILURE {momchf} / {dadchf}	☐ NO ☐ YES → **Age first diagnosed____ {magechf}** (Do not know age ☐) ☐ NOT SURE	☐ NO ☐ YES → **Age first diagnosed ____ {dagechf}** (Do not know age ☐) ☐ NOT SURE
LOUD OR DISRUPTIVE SNORING {momsnor} / {dadsnor}	☐ NO ☐ YES → **Age first diagnosed____ {magesnor}** (Do not know age ☐) ☐ NOT SURE	☐ NO ☐ YES → **Age first diagnosed ____ {dagesnor}** (Do not know age ☐) ☐ NOT SURE
EXCESSIVE (TOO MUCH) SLEEPINESS {momslp} / {dadslp}	☐ NO ☐ YES → **Age first diagnosed____ {mageslp}** (Do not know age ☐) ☐ NOT SURE	☐ NO ☐ YES → **Age first diagnosed ____ {dageslp}** (Do not know age ☐) ☐ NOT SURE

HEART ATTACK (Myocardial Infarction) {mommi} / {dadmi}	□ NO □ YES → **Age first diagnosed____ {magemi}** (Do not know age □) □ NOT SURE	□ NO □ YES → **Age first diagnosed ____ {dagemi}** (Do not know age □) □ NOT SURE
STROKE (TIA) {momstrok} / {dadstrok}	□ NO □ YES → **Age first diagnosed____ {magestro}** (Do not know age □) □ NOT SURE	□ NO □ YES → **Age first diagnosed ____ {dagestro}** (Do not know age □) □ NOT SURE
Angioplasty or By-Pass Surgery {mombypas} / {dadbipas}	□ NO □ YES → **Age first diagnosed____ {magebypa}** (Do not know age □) □ NOT SURE	□ NO □ YES → **Age first diagnosed ____ {dagebypa}** (Do not know age □) □ NOT SURE
CANCER {momcancr} / {dadcancr}	□ NO □ YES → **Age first diagnosed _____ {magecanc}** (Do not know age □) *What type of cancer?* _____ **{momspecc}** □ NOT SURE	□ NO □ YES → **Age first diagnosed _____ {dagecanc}** (Do not know age □) *What type of cancer?* _____ **{dadspecc}** □ NOT SURE
DEPRESSION {momdepre} / {daddepre}	□ NO □ YES → **Age first diagnosed____ {magedepr}** (Do not know age □) □ NOT SURE	□ NO □ YES → **Age first diagnosed ____ {dagedepr}** (Do not know age □) □ NOT SURE
DIABETES {momdiabe} / {daddiabe}	□ NO □ YES → **Age first diagnosed____ {magediab}** (Do not know age □) □ NOT SURE	□ NO □ YES → **Age first diagnosed ____ {dagediab}** (Do not know age □) □ NOT SURE
ASTHMA {momasthm} / {dadasthm}	□ NO □ YES → **Age first diagnosed____ {mageasth}** (Do not know age □) □ NOT SURE	□ NO □ YES → **Age first diagnosed ____ {dageasth}** (Do not know age □) □ NOT SURE
Restless Legs or Periodic Movement Disorder (PLMS) {momlegs} / {dadlegs}	□ NO □ YES → **Age first diagnosed____ {mageleg}** (Do not know age □) □ NOT SURE	□ NO □ YES → **Age first diagnosed ____ {dageleg}** (Do not know age □) □ NOT SURE

Muscular Dystrophy {mommd} / {dadmd}	□ NO □ YES → **Age first diagnosed____ {magemd}** (Do not know age □) □ NOT SURE	□ NO □ YES → **Age first diagnosed ____ {dagemd}** (Do not know age □) □ NOT SURE
Attention Deficit Disorder {momadd} / {dadadd}	□ NO □ YES → **Age first diagnosed____ {mageadd}** (Do not know age □) □ NOT SURE	□ NO □ YES → **Age first diagnosed ____ {dageadd}** (Do not know age □) □ NOT SURE
Tourettes Syndrome {momtoure} / {dadtoure}	□ NO □ YES → **Age first diagnosed____ {magetour}** (Do not know age □) □ NOT SURE	□ NO □ YES → **Age first diagnosed ____ {dagetour}** (Do not know age □) □ NOT SURE
Sickle Cell Disease {momsickl} / {dadsickl}	□ NO □ YES → **Age first diagnosed____ {magesick}** (Do not know age □) □ NOT SURE	□ NO □ YES → **Age first diagnosed ____ {dagesick}** (Do not know age □) □ NOT SURE
Other Significant Medical Condition {momothsi} / {dadothsi}	□ NO □ YES → **Age first diagnosed____ {mageoths}** (Do not know age □) *Please specify:* _____ □ NOT SURE	□ NO □ YES → **Age first diagnosed____ {dageoths}** (Do not know age □) *Please specify:* _____ □ NOT SURE

78. Is your Mother alive {momlive}?

☐ No How old was she when she died **{momdied}**? _____
Cause of death (if known) **{momcaus}**? _____

☐ Yes How old is she **{momage}**? _____

79. Is your Father alive {dadlive}?

☐ No How old was he when he died **{daddied}**? _____
Cause of death (if known) **{dadcaus}**? _____

☐ Yes How old is he**{dadage}**? _____

80. Do you have any full (**biological**) brothers or sisters (**same** mother and father as you) **{brosis}**?

☐ No
☐ Yes

IF YES:

How many ? Brothers **{nobro}**_____ Sisters **{nosis}**_____
How many are living ? Brothers **{brolive}**_____ Ages **{broage}** ____ ____ ____ ____ ____ ____
Sisters **{sislive}** _____ Ages **{sisage}** ____ ____ ____ ____ ____ ____

If any of your **brother(s)** have died, please list ages when deceased:

Age died **{broaged1}** ____ Cause of death (if known) **{brocaus1}** _____
Age died **{broaged2}** ____ Cause of death (if known) **{brocaus2}** _____
Age died **{broaged3}** ____ Cause of death (if known) **{brocaus3}** _____

If any of your **sister(s)** have died, please list ages when deceased:

Age died **{sisaged1}** ____ Cause of death (if known) **{siscaus1}** _____
Age died **{sisaged2}** ____ Cause of death (if known) **{siscaus2}** _____
Age died **{sisaged3}** ____ Cause of death (if known) **{siscaus3}** _____

81. Have any of your brothers or sisters had the following?:

	NO	YES	NOT SURE
Sleep Apnea **{sibosa}**	☐	☐ If YES: How many: Brothers **{bosano}**? ____ Sisters **{sosano}**? ____	☐
Narcolepsy **{sibnarc}**	☐	☐ If YES: How many: Brothers **{bnarcno}**?____ Sisters **{snarcno}**? ____	☐
Congestive Heart Failure **{sibchf}**	☐	☐ If YES: How many: Brothers **{bchfno}**? ____ Sisters **{schfno}**? ____	☐
High Blood Pressure **{sibbp}**	☐	☐ If YES: How many: Brothers **{bbpno}**? ____ Sisters **{sbpno}**? ____	☐
Sudden Infant Death Syndrome (SIDS)**{sibsids}**	☐	☐ If YES: How many: Brothers **{bsidsno}**? ____ Sisters **{ssidsno}**? ____	☐
Near Miss SIDS or Acute Life Threatening Episode (ALTE)**{sibnms}**	☐	☐ If YES: How many: Brothers **{bnmsno}**? ____ Sisters **{snmsno}**? ____	☐
Loud/ Disruptive Snoring**{sibsnor}**	☐	☐ If YES: How many: Brothers **{bsnorno}**? ____ Sisters **{ssnorno}**? ____	☐
Excessive (too much) Sleepiness **{sibslp}**	☐	☐ If YES: How many: Brothers **{bslpno}**? ____ Sisters **{sslpno}**? ____	☐
Heart Attack (Myocardial Infarction) **{sibmi}**	☐	☐ If YES: How many: Brothers **{bmino}**? ____ Sisters **{smino}**? ____	☐
Stroke (or a TIA) **{sibstrok}**	☐	☐ If YES: How many: Brothers **{bstrokno}**? ___ Sisters **{sstrokno}**? ___	☐
Angioplasty or By-Pass Surgery **{sibbypas}**	☐	☐ If YES: How many: Brothers **{bbypasno}**? ___ Sisters **{sbypasno}**?___	☐
Cancer **{sibcancr}** **What Type {sibcansp}?** _____	☐	☐ If YES: How many: Brothers **{bcancrno}**? ___ Sisters **{scancrno}**? ___	☐
Depression **{sibdepre}**	☐	☐ If YES: How many: Brothers **{bdepreno}**? ___ Sisters **{sdepreno}**? ___	☐
Diabetes **{sibdiabe}**	☐	☐ If YES: How many: Brothers **{bdiabeno}**? ___ Sisters **{sdiabeno}**? ___	☐
Asthma **{sibasthm}**	☐	☐ If YES: How many: Brothers **{basthmno}**?___ Sisters **{sasthmno}**?___	☐
Emphysema **{sibemphy}**	☐	☐ If YES: How many:	

Brothers **{bemphyno}**?___ Sisters **{semphyno}**?__ ☐

Restless Legs or Periodic Movement Disorder (PLMS)**{siblegs}** ☐ ☐ If YES: How many:
Brothers **{blegsno}**? ____ Sisters **{slegsno}**? ____ ☐

Muscular Dystrophy **{sibmd}** ☐ ☐ If YES: How many:
Brothers **{bmdno}**? ____ Sisters **{smdno}**? ____ ☐

Tourettes Syndrome **{sibtoure}** ☐ ☐ If YES: How many:
Brothers **{btoureno}**?___ Sisters **{stoureno}**?____ ☐

Attention Deficit Disorder **{sibadd}** ☐ ☐ If YES: How many:
Brothers **{baddno}**? ____ Sisters **{saddno}**? ____ ☐

Sickle Cell Disease **{sibsickl}** ☐ ☐ If YES: How many:
Brothers **{bsicklno}**? ____ Sisters **{ssicklno}**? ___ ☐

Other Significant Medical Condition? **{sibsigmd}** ☐ ☐ If YES: How many:
Brothers **{bothmdno}**?___Sisters **{sothmdno}**?___ ☐

Please Specify? _____

82. Do you have any children **{kids}**?
☐ No ☐ Yes

IF YES:

How many? Sons **{nosons}** _____ Daughters**{nodaugh}** _____

How many are living? Sons **{sonslive}** _____ Ages **{sonage}** _____ _____ _____ _____
Daughters **{daulive}**_____ Ages **{dauage}** _____ _____ _____ _____

If any of your **son(s)** have died, please list his (their) ages when deceased:

Age died **{sonaged1}** ____ Cause of death (if known) **{soncaus1}** _____
Age died **{sonaged2}** ____ Cause of death (if known) **{soncaus2}** _____
Age died **{sonaged3}** ____ Cause of death (if known) **{soncaus3}** _____

If any of your **daughter(s)** have died, please list her (their) ages when deceased:

Age died **{dauaged1}** ____ Cause of death (if known) **{daucaus1}**
_____
Age died **{dauaged2}** ____ Cause of death (if known) **{daucaus2}**
_____
Age died **{dauaged3}** ____ Cause of death (if known) **{daucaus3}**
_____

Have any of your children had:

	NO	YES		NOT SURE
Sleep Apnea **{kidosa}**	☐	☐	If YES: How many: Sons **{sonosa}**? ____ Daughters **{dauosa}**? ____	☐
Narcolepsy **{kidnarc}**	☐	☐	If YES: How many: Sons **{sonnarc}**?____ Daughters **{daunarc}**? ____	☐
Congestive Heart Failure **{kidchf}**	☐	☐	If YES: How many: Sons **{sonchf}**? ____ Daughters **{dauchf}**? ____	☐
High Blood Pressure **{kidbp}**	☐	☐	If YES: How many: Sons **{sonbp}**? ____ Daughters **{daubp}**? ____	☐
Sudden Infant Death Syndrome (SIDS) **{kidsids}**	☐	☐	If YES: How many:	

Sons **{sonsids}**? ____ Daughters **{dausids}**? ____ ☐

Near Miss SIDS or Acute Life Threatening Episode (ALTE)**{kidnms}**
☐ ☐ If YES: How many:
Sons **{sonnms}**? ____ Daughters **{daunms}**? ____ ☐

Loud/ Disruptive Snoring**{kidsnor}** ☐ ☐ If YES: How many:
Sons **{sonsnor}**? ____ Daughters **{dausnor}**? ____ ☐

Excessive (too much) Sleepiness **{kidslp}**
☐ ☐ If YES: How many:
Sons **{sonslp}**? ____ Daughters **{dauslp}**? ____ ☐

Heart Attack (Myocardial Infarction) **{kidmi}**
☐ ☐ If YES: How many:
Sons **{sonmi}**? ____ Daughters **{daumi}**? ____ ☐

Stroke (or a TIA) **{kidstrok}** ☐ ☐ If YES: How many:
Sons **{sonstrok}**? ___ Daughters **{daustrok}**? ___ ☐

Angioplasty or By-Pass Surgery **{kidbypas}**
☐ ☐ If YES: How many:
Sons **{sonbypas}**? ___ Daughters **{daubypas}**?___ ☐

Cancer **{kidcancr}** ☐ ☐ If YES: How many:
What Type {kidcansp}? _____ Sons **{soncancr}**? ___ Daughters **{daucancr}**? ___ ☐

Depression **{kiddepre}** ☐ ☐ If YES: How many:
Sons **{sondepre}**? ___ Daughters **{daudepre}**? __ ☐

Diabetes **{kiddiabe}** ☐ ☐ If YES: How many:
Sons **{sondiabe}**? ___ Daughters **{daudiabe}**? ___ ☐

Asthma **{kidasthm}** ☐ ☐ If YES: How many:
Sons **{sonasthm}**?___ Daughters **{dauasthm}**?___ ☐

Emphysema **{kidemphy}** ☐ ☐ If YES: How many:
Sons **{sonemphy}**?___ Daughters **{dauemphy}**?__ ☐

Restless Legs or Periodic Movement Disorder (PLMS)**{kidlegs}**
☐ ☐ If YES: How many:
Sons **{sonlegs}**? ____ Daughters **{daulegs}**? ____ ☐

Muscular Dystrophy **{kidmd}** ☐ ☐ If YES: How many:
Sons **{sonmd}**? ____ Daughters **{daumd}**? ____ ☐

Tourettes Syndrome **{kidtoure}** ☐ ☐ If YES: How many:
Sons **{sontoure}**?___ Daughters **{dautoure}**?___ ☐

Attention Deficit Disorder **{kidadd}** ☐ ☐ If YES: How many:
Sons **{sonadd}**? ____ Daughters **{dauadd}**? ____ ☐

Sickle Cell Disease **{kidsickl}** ☐ ☐ If YES: How many:
Sons **{sonsickl}**? ____ Daughters **{dausickl}**? ___ ☐

Other Significant Medical Condition? **{kidsigmd}**
Please Specify? _____ ☐ ☐ If YES: How many:
Sons **{sonothmd}**?___ Daughters **{dauothmd}**?__ ☐

83. **Have any of the following biological relatives had….**

Ovarian Cancer {ovarcanc}?		Before Age 50	Age 50 to 59	Age 60 to 69	Age 70+	Age Unknown
o NO ↓	o Yes → Mother **{movarage}**	o	o	o	o	o
	o Yes → Sister **{soverage}**	o	o	o	o	o

Breast Cancer {breacanc}?		Before Age 50	Age 50 to 59	Age 60 to 69	Age 70+	Age Unknown
o NO ↓	o Yes → Mother **{mbreaage}**	o	o	o	o	o
	o Yes → One Sister **{sbreaage}**	o	o	o	o	o
	o Yes → Addl' Sister **{addsbage}**	o	o	o	o	o
	o Yes → Daughter **{dbreaage}**	o	o	o	o	o

Colon or Rectal Cancer? {colocancr}		Before Age 50	Age 50 to 59	Age 60 to 69	Age 70+	Age Unknown
o NO ↓	o Yes → Parent **{pcoloage}**	o	o	o	o	o
	o Yes → One Sibling **{sibcolag}**	o	o	o	o	o
	o Yes → Addl' Sibling **{adsibage}**	o	o	o	o	o

Pancreatic Cancer {panccanr}?		Before Age 50	Age 50 to 59	Age 60 to 69	Age 70+	Age Unknown
o NO ↓	o Yes → Parent **{ppancage}**	o	o	o	o	o
	o Yes → Sibling **{spancage}**	o	o	o	o	o

Melanoma {melonoma}?		Before Age 50	Age 50 to 59	Age 60 to 69	Age 70+	Age Unknown
o NO ↓	o Yes → Parent **{pmeloage}**	o	o	o	o	o
	o Yes → Sibling **{smeloage}**	o	o	o	o	o
	o Yes → Offspring **{omeloage}**	o	o	o	o	o

Glaucoma {glaucoma}?		Before Age 50	Age 50 to 59	Age 60 to 69	Age 70+	Age Unknown
o NO ↓	o Yes → Parent **{pglauage}**	o	o	o	o	o
	o Yes → Sibling **{sglauage}**	o	o	o	o	o

MEDICAL HISTORY

84. Have you **EVER** smoked cigarettes **{smoked}**? ('No' means less than 20 packs in a lifetime or less than 1 cigarette for 1 year)

☐ No ☐ Yes

IF YES:

How old were you when you first started regular cigarette smoking **{agesmok}**? _____ Age in years

On the average, over the entire time you smoked, how many cigarettes did you smoke each day **{avgsmok}**? _____ Cigarettes per day

Over the **last month**, have you smoked at least 1 cigarette per day **{monsmoke}**?

☐ No ☐ Yes

IF YES, how many cigarettes do you now smoke each day **{nowsmoke}**?
_____ Cigarettes per day

IF NO, how old were you when you stopped smoking **{stopsmok}**?
_____ Age in years

85. Have you ever smoked cigars/cigarillos **{cigar}**?

☐ No ☐ Yes

Have you ever smoked a pipe **{pipe}**?

☐ No ☐ Yes

IF YES:

How old were you when you first started regular cigar smoking **{agecigs}**? _____ Age in years
How old were you when you first started regular pipes smoking **{agepipe}**? _____ Age in years

On the average, over the entire time you smoked, how many cigars/pipes did you Smoke each day? _____ cigar per day **{avgcigs}**
_____ pipes (bowls) per day **{avgpipe}**

Over the **last month**, have you smoked at least 1 cigar per day **{moncigs}**? ☐ No ☐ Yes
Over the **last month**, have you smoked at least 1 pipe per day **{monpipe}**? ☐ No ☐ Yes

IF YES, how many cigar/pipes do you now smoke each day?
_____ Cigars per day **{nowcigs}**
_____ Pipes (bowls) per day **{nowpipe}**

IF NO, how old were you when you stopped smoking?
_____ Age in years (Cigars) **{stopcigs}**
_____ Age in years (Pipes) **{stoppipe}**

86.

Have you ever had any pain or discomfort in your chest **{painches}**? ☐No ☐Yes

Have you ever had any pressure or heaviness in your chest **{presches}**? ☐No ☐Yes

IF YOU ANSWERED YES TO EITHER QUESTON IN BOX 86 PLEASE ANSWER QUESTIONS IN THE BOX BELOW:

Do you get chest discomfort/pressure when you walk uphill or hurry **{upchest}?**
☐ No ☐ Yes ☐ Never hurry or walk uphill

Do you get chest discomfort/pressure when you walk at an ordinary pace on ground level **{levchest}**? ☐ No ☐ Yes

What do you do if you get chest discomfort/pressure while you are walking **{dochest}**?
☐ Stop or slow down (1) ☐ Carry on (2)

If you stand still, what happens to your chest discomfort/pressure **{stilches}**?
☐ Relieved (1) ☐ Not relieved (2)

How soon **{soonches}**? ☐10 minutes or less (1) ☐ More than ten minutes (2)

Did you see a doctor because of this pain (or discomfort) **{docpain}**? ☐ No ☐Yes

If **yes**, what did he/she say **{docsay}**? _____

87. Have you ever had enlarged tonsils or adenoids **{enltons}**?

☐ No ☐Yes ☐ Not Sure

IF YES:

Did a doctor diagnose it **{tondiag}**? ☐ No ☐Yes ☐Not sure

How old were you when this was first noted **{tonage}**? _____ years ☐Not sure

Are your tonsils still enlarged **{tonpres}**? ☐No ☐Yes ☐ Not sure

88. Have your tonsils and/or adenoids been removed **{tonsaden}**?

☐ No ☐Yes ☐ Not Sure

IF YES:

How old were you when they were removed **{agerem}**? _____ years or ☐ Not Sure

Reason they were removed **{reasrem}**:

- ☐ Infection (1)
- ☐ Allergies (2)
- ☐ Enlarged/Swollen (3)
- ☐ Failure to Thrive (4)
- ☐ Other (5)
- ☐ Apnea (6)
- ☐ Not Sure (-2)

89. Have you ever had allergies to dust, molds, grass or pollen **{allergy}**?

☐ No ☐ Yes ☐ Not Sure

IF YES:

Was this confirmed with a skin test **{skintst}**?

☐No ☐ Yes ☐Not Sure

90. Have you ever had a problem with alcohol abuse or alcoholism **{alcism}**?

☐ No ☐ Yes

IF YES:

How old were you when the condition was first noted **{alcage}**? _____ Years ☐ Not Sure

Is this condition still present **{alcpres}**? ☐ No ☐Yes ☐ Not Sure

91. In a typical week **during the past year**, on how many days did you consume an alcoholic beverage of any type **{alcohday}**?

☐ 0 days ☐ 1 day ☐ 2 days ☐ 3 days ☐ 4 days ☐ 5 days
☐ 6 days ☐ 7 days

92. In a typical month during the past year, what was the largest number of drinks of beer, wine and/or liquor you may have had in one day **{nodrinks}**?

- ☐ 0 (0)
- ☐ 1-2 (1)
- ☐ 3-5 (2)
- ☐ 6-9 (3)

☐ 10-15 (4)
☐ 15 or more (5)

93. When you drink alcohol, do you usually drink during the two hours before bedtime **{bedalcl}**?

☐ No ☐ Yes

94. On the average, how often do you drink beverages containing caffeine (cola, coffee, tea, etc.) **{cafbevad}**?

☐ None (0)
☐ Less than one cup a day (1)
☐ Approximately one cup (8 ozs.) a day (2)
☐ More than one cup, less than three cups a day (3)
☐ More than three cups a day (4)

95. Have you ever had any of these physician-diagnosed illnesses or procedures?

			IF YES , WHEN FIRST DIAGNOSED?		
	No	**Yes →**	**Approximate Year Diagnosed**	**Approximate Age First Diagnosed**	**Not Sure**
Sleep Apnea **{slapndia}/{apndiayr}/{agediaap}**					
Narcolepsy **{dianarc}/{dianaryr}/{agediana}**					
Loud/Disruptive Snoring **{diasnor}/{diasnoyr}/{agediasn}**					
Excessive (too Much) Sleepiness **{diaexslp}/{diaexsyr}/{agediaex}**					
Restless Legs or Periodic Leg Movement Disorder (PLMs) **{dialegs}/{dialegyr}/{agediale}**					
Elevated Cholesterol **{diachol}/{diachlyr}/{agediach}**					
Near Miss SIDS or Acute Life Threatening Episode (ALTE) **{dianm}/{dianmyr}/{agedianm}**					
High Blood Pressure (Hypertension) **{bpdiag}/{diabpyr}/{bpage}**					
Myocardial infarction (heart attack) **{hrtdiag}/{diahrtyr}/{hrtage}**					
Diabetes **{diadiag}/{diadiayr}/{diaage}**					
Irregular Heart Beat **{irrdiag}/{diairryr}/{irrage}**					
Angina pectoris or chest pain from a heart condition **{angdiag}/{angdiayr}/{angage}**					

Coronary Bypass **{bypass}/{bydiagyr}/{bypasage}**					
Coronary Angioplasty **{angiop}/{angioyr}/{angioage}**					
Congestive heart failure **{htfdiag}/{htfdiayr}/{htfage}**					
Implant of Cardiac Pacemaker **{pacemak}/{pacdiayr}/{pacemage}**					
Other Heart Disease **{headiag}/{heaageyr}/{heaage}** Specify **{heartsp}**:					
Stroke (CVA) **{strodiag}/{strodiyr}/{storage}**					
Carotid surgery (Endarterectomy) **{endart}/{endartyr}/{endarage}**					
TIA (Transient ischemic attack) **{tiadiag}/{tiadiayr}/{tiaage}**					
Peripheral artery disease of legs or claudication (not varicose veins) **{partdiag}/{partdiyr}/{partage}**					
Osteoporosis **{ostediag}/{ostdiayr}/{ostage}**					
Gastric of duodenal ulcer **{gulcdiag}/{guldiayr}/{gulcage}**					
Parkinson's Disease **{parkdiag}/{pardiayr}/{parkage}**					
	No	**Yes →**	**Approximate Year Diagnosed**	**Approximate Age First Diagnosed**	**Not Sure**
Ulcerative Colitis/Crohn's **{crohdiag}/{crodiayr}/{crohage}**					
Kidney stones **{kidndiag}/{kidndiyr}/{kidnage}**					
Liver disease **{livediag}/{livdiayr}/{liverage}**					
Kidney Failure **{kidfdiag}/{kfdiagyr}/{kidfage}**					
Muscular Dystrophy **{mdysdiag}/{mdysdiyr}/{mdysage}**					
Tourettes Syndrome **{tourdiag}/{toudiayr}/{toursage}**					
Sickle Cell Disease **{sicdiag}/{sicdiayr}/{sicage}**					
Anemia **{anemdiag}/{anediayr}/{anemage}**					
Cirrhosis of the Liver **{cirrdiag}/{cirdiayr}/{cirrage}**					
Hepatitis **{hepadiag}/{hepdiayr}/{hepaage}**					
Asthma **{astdiag}/{astdiayr}/{astage}**					
Chronic Bronchitis **{brodiag}/{brodiayr}/{bronage}**					
Emphysema **{empdiag}/{empdiayr}/{empage}**					
Pneumonia **{pneudiag}/{pnediayr}/{pneuage}**					
Sinus					

{sindiag}/{sindiayr}/{sinage}					
Hay Fever **{haydiag}/{haydiayr}/{hayage}**					
Nose with a deviated septum **{devdiag}/{devdiayr}/{devage}**					
Adenoidectomy **{adendiag}/{adediayr}/{adenage}**					
Tonsillectomy **{tonsdiag}/{tondiayr}/{tondiage}**					
Insomnia **{insodiag}/{insdiayr}/{insomage}**					
Anxiety Disorder **{anxdiag}/{anxdiayr}/{anxage}**					
Attention Deficit Disorder **{adddiag}/{adddiayr}/{adage}**					
Behavior Disorder **{behdiag}/{behdiayr}/{behage}**					
Gout **{goutdiag}/{goudiayr}/{goutage}**					
Multiple sclerosis **{mscdiag}/{mscdiayr}/{msclage}**					
Rheumatoid Arthritis **{rheudiag}/{rhediayr}/{rheuage}**					
Thyroid Disease **{thydiag}/{thydiayr}/{thyage}**					
	No	**Yes →**	**Approximate Year Diagnosed**	**Approximate Age First Diagnosed**	**Not Sure**
Depression **{depdiag}/{depdiayr}/{depage}**					
Eczema **{eczdiag}/{eczdiayr}/{eczage}**					
Other Psychiatric Disease **{psydiag}/{psydiayr}/{psyage}** **Specify {psychsp} :**					
Cancer **{cancdiag}/{candiayr}/{cancage}** **Specify {cancesp}:**					
Other Major Surgery **{otmasurg}/{surdiayr}/{surgage}** **Specify {majsursp}:**					
Other Significant Medical Condition **{osmcdiag}/{osmdiayr}/{osmcage}** **Specify {osmcsp}:**					

96. Have you been hospitalized since we last saw you **{Hosp}**?
☐ No ☐ Yes

IF YES, how many times **{Hosptim}**? _____

Were you hospitalized for heart disease **{Hosphrt}**?
☐ No ☐ Yes

Describe reasons for hospitalization **{hosreas}**.

_____

_____

97. Have you ever been diagnosed to have sleep apnea **{diaapn}**?
☐ No ☐ Yes

IF YES, give the name of the physician or clinic **{namdoc}**: _____
What year was this diagnosed in **{yrdiagn}**? _____

IF YES, were any of the following treatments recommended or prescribed?

CPAP **{CPAP}**	☐No	☐Yes
UPPP **{UPPP}**	☐No	☐Yes
Tonsillectomy **{Simple}**	☐No	☐Yes
Nose Surgery **{Nosesur}**	☐No	☐Yes
Nasal Dilators **{Nasaldil}**	☐No	☐Yes
Dental Device **{Dendev}**	☐No	☐Yes
Laser treatment **{Lazertx}**	☐No	☐Yes
Somnoplasty (radio frequency) **{Somnoply}**	☐No	☐Yes

98. If you were prescribed CPAP, are you still using this on a regular basis **{regbas}**?
☐ No ☐Yes ☐ Not Applicable (-1)
If **NO**, Why **{nouse}**? _____

99. Have you had surgery for snoring or sleep apnea **{snorsur}**?
☐ No ☐Yes

If YES, When and where did you have the surgery **{whenwhe}**?

_____

100. Have there been any **deaths, serious accidents, or hospitalizations** for serious medical illnesses in any of your first-degree family members (parents / children / brothers / sisters) since we last contacted you **{injury}**?

☐ No ☐Yes ☐Not Sure

Name of Relative	Relationship to you	Event (Hospitalization, Accident,Death)	Date(s)

{injrel1}: _____

{injrel2}: _____

{injrel3}: _____

{injrel4}: _____

{injrel5}: _____

101. What is your current employment status (check one) **{employ}**?

☐ Working full-time (1)
☐ Working part-time (2)
☐ Home keeper (3)
☐ Unemployed, looking for work (4)
☐ Unemployed, not looking for work (5)
☐ Student (6)
☐ Retired (7)
☐ Unable to work because (please specify) (8)
_____

102. Most recent occupation **{RecOcc}**: _____

103. Do you work rotating night shifts**{RotNite}**? ☐ No ☐ Yes

104. Do you work steady night shifts **{StdyNite}**? ☐ No ☐ Yes

105. Did you have help completing this questionnaire **{AskQst}**?

☐No ☐ Yes

IF YES: Is the person who helped you someone who:
(Check all appropriate)

☐ Shares a bedroom with you **{sharbed}**. (1)
☐ Lives in the same house, but not in the same bedroom **{samhse}**. (2)
☐ Lives in a different house, but has observed your sleep **{obslp}**. (3)
☐ Lives elsewhere, has not observed your sleep **{noobser}**. (4)

106. What are your living arrangements **{livearra}**?
☐ Alone (1)
☐ With Spouse or partner (2)
☐ With other family member (3)
☐ Other (4)

107. Where did you complete this questionnaire **{whereqst}**?

☐ In the clinic or doctor's office (1)
☐ At home (2)
☐ At the sleep laboratory (3)
☐ Other *Please Specify:*_____ (4)

108. Have you ever had an overnight sleep study in a hospital **{Havepsg}**?

☐No ☐Yes ☐ Don't know
If **YES**, When **{WhenPsg}**? _____

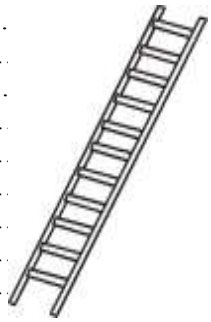
109. What is your household income **{hsincome}**?

- ☐ Under $5,000 (1)
- ☐ $ 5,000 to $ 9999 (2)
- ☐ $ 10,000 to $ 19,999 (3)
- ☐ $ 20,000 to $ 29,999 (4)
- ☐ $ 30,000 to $ 39,999 (5)
- ☐ $ 40, 000 to $ 49,999 (6)
- ☐ $ 50,000 or more (7)

110. Think of this ladder as representing where people stand in the United States.

At the top of the ladder are the people who are the best off – those who have the most money, the most education, and the most respectable jobs. The bottom are the people who are the worst off – those who have the least money, least education, and the least respected jobs or no job.

(10) O……..……
O……
O……..…….
O……
O……
O……
O……
O……
(1) O……..



Where would you place yourself on this ladder **{ladder}**? *One would be at the bottom of the ladder, 10 would be the top of the ladder.* **Fill the circle that best represents where you think you stand, relative to other people in the United States.**

111. Did you doze off while completing this questionnaire **{SlpQst}**?

☐ No ☐ Yes

112. Over the last 3 months, have you shared a room on a regular basis with someone who has been in a position to hear or observe you breathing while asleep **{SlpHear}**?

☐ No ☐ Yes

113. Please indicate the name of someone at a ***DIFFERENT PERMANENT ADDRESS*** to whom we might write in the event we are unable to contact you:

Name **{diffname}**: _____

Address **{diffaddr}**: _____

City **{diffcity}**: _____

State / ZIP Code: _____

Modified 11/04/03 (03/18/08) jea