Sleep Questionnaire HCHS/SOL Sleep Ancillary Study
ID NUMBER: FORM CODE: SPE Contact VERSION: A 08/16/10 Occasion SEQ #
ADMINISTRATIVE INFORMATION 0a. Completion Date: /
Instructions: Enter the answer given by the participant for each response. The special value, "Q", is allowed for cases where the response 'Don't know/refused' is not listed as an option.
The following two questions refer to the times you get in and out of bed in order to sleep (not including naps).
1. What time do you usually go to bed?
spea1a_2401 a. On weekdays?
spea1b_2401 b. On weekends?
2. What time do you usually wake up?
spea2a_2401 a. On weekdays?
spea2b_2401 b. On weekends?
spea3 3. During a usual week, how many times do you nap for 5 minutes or more?

0
1 🗌
2 🗌
3 🗌

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The next questions ask about your sleep habits. Please choose *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*.

		No, not in the past 4 weeks	Yes, less than once a week	Yes, 1 or 2 times a week	Yes, 3 or 4 a week	Yes, 5 or more times a week
spea4	4. Did you have trouble falling asleep?	1 🗌	2 🗌	3 🗌	4	5 🗌
spea5	5. Did you wake up several times at night?	1	2 🗌	3	4	5 🗌
spea6	6. Did you wake up earlier than you planned to?	1	2 🗌	3	4	5 🗌
spea7	7. Did you have trouble getting back to sleep after you woke up too early?	1 🗌	2 🗌	3	4 🗌	5 🗌
spea8	8. Did you take sleeping pills to help you sleep?	1	2 🗌	3	4	5 🗌
spea9	9. Did you have sleep difficulties that made you very irritable?	1 🗌	2	3	4 🗌	5 🗌
spea10	10. Did you feel overly sleepy during the day?	1	2 🗌	3	4	5 🗌

spea11 11. Overall, was your typical night's sleep during the past 4 weeks:

uning the past 4 weeks.	
Very sound or restful	0
Sound or restful	1
Average quality	2
Restless	3
Very restless	4

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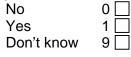
12. What is the chance that you would doze off or fall asleep (not just "feel tired") in each of the following situations? If you are never or rarely in the situation, please give your best guess for what would happen. (*Choose one box for each item*)

spea12a a. Sitting and reading		No Chance 1 🗌	Slight Chance 2 🗌	Moderate Chance 3	High Chance 4 🗌
spea12b b. Watching TV		1	2	3	4
spea12c c. Sitting inactive in a public (such as a theater or a me	-	1 🗌	2 🗌	3 🗌	4 🗌
spea12d d. Riding as a passenger in an hour without a break	a car for	1 🗌	2 🗌	3 🗌	4 🗌
spea12e e. Lying down to rest in the when circumstances perm		1	2 🗌	3 🗌	4
spea12f f. Sitting and talking to some	eone	1	2 🗌	3	4
spea12g g. Sitting quietly after a lunc	h without alcohol	1 🗌	2 🗌	3	4
spea12h h. In a car, while stopped fo traffic	r a few minutes in	1 🗌	2 🗌	3 🗌	4 🗌
spea12i i. At the dinner table		1	2	3	4
spea12j j. While driving		1 🗌	2	3 🗌	4
spea13 13. How often do you snore spea14 14. How often do you have	Never Rarely (1-2 nights Sometimes (3-5 r Always or almost Don't know	s a week) hights a week) always (6-7 nig p breathing duri s a week) hights a week)	9 ng your sleep? 1 2 3		
spea15 15. Do you ever experience in your legs?	a desire to move ye	our legs becaus	e of discomfort	or disagreeable	sensations

No	$0 \square \rightarrow END QUESTIONNAIRE$
Yes	1
Don't know	9 $\Box \rightarrow $ END QUESTIONNAIRE

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spea16 16. Do you sometimes feel the need to move to relieve the discomfort, for example by walking, or to relieve the discomfort by rubbing your legs?



spea17 17. Are these symptoms worse when you are at rest, with at least temporary relief by activity?

No	0 🗌
Yes	1 🗌
Don't know	9 🗌

spea18 18. Are these symptoms worse later in the day or at night?

0 🗌
1 🗌
9 🗌