HeartBEAT
Heart Biomarker Evaluation In Apnea Treatment

ID						Namecode				

Date			/			/		

Staff ID			

Please complete the following questions and return in the provided envelope.

Snoring Questions

doyousnore
1. Do you snore?
- ☐ a. Yes
- ☐ b. No (*skip to #5)
- ☐ c. Don't know (*skip to #5)

If you snore:

snoringis
2. Your snoring is:
- ☐ a. Slightly louder than breathing
- ☐ b. As loud as talking
- ☐ c. Louder than talking
- ☐ d. Very loud – can be heard in adjacent rooms

oftensnore
3. How often do you snore?
- ☐ a. Nearly every day
- ☐ b. 3-4 times a week
- ☐ c. 1-2 times a week
- ☐ d. 1-2 times a month
- ☐ e. Never or nearly never

bothered
4. Has your snoring ever bothered other people?
- ☐ a. Yes
- ☐ b. No
- ☐ c. Don't know

quitbreath
5. Has anyone noticed that you quit breathing during your sleep?
- ☐ a. Nearly every day
- ☐ b. 3-4 times a week
- ☐ c. 1-2 times a week
- ☐ d. 1-2 times a month
- ☐ e. Never or nearly never

Sleeping Questions

feeltired
6. How often do you feel tired or fatigued after you sleep?
- ☐ a. Nearly every day
- ☐ b. 3-4 times a week
- ☐ c. 1-2 times a week
- ☐ d. 1-2 times a month
- ☐ e. Never or nearly never

wakingtime
7. During your waking time, do you feel tired, fatigued or not up to par?
- ☐ a. Nearly every day
- ☐ b. 3-4 times a week
- ☐ c. 1-2 times a week
- ☐ d. 1-2 times a month
- ☐ e. Never of nearly never

nodded
8. Have you ever nodded off or fallen asleep while driving a vehicle?
- ☐ a. Yes
- ☐ b. No (*skip to #10)

If yes:

nodoften
9. How often does this occur?
- ☐ a. Nearly every day
- ☐ b. 3-4 times a week
- ☐ c. 1-2 times a week
- ☐ d. 1-2 times a month
- ☐ e. Never or nearly never

Blood Pressure Question

highbp
10. Do you have high blood pressure?
- ☐ a. Yes
- ☐ b. No
- ☐ c. Don't know

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

		Would Never Doze	Slight Chance of Dozing	Moderate Chance of Dozing	High Chance of Dozing
sitread	a. **Sitting and reading**	☐	☐	☐	☐
watchtv	b. **Watching TV**	☐	☐	☐	☐
inact	c. **Sitting, inactive, in a public place (e.g., a movie theater or classroom)**	☐	☐	☐	☐
passeng	d. **Riding as a passenger in a car for an hour without a break**	☐	☐	☐	☐
lying	e. **Lying down to rest in the afternoon when circumstances permit**	☐	☐	☐	☐
sittalk	f. **Sitting and talking to someone**	☐	☐	☐	☐
sitquiet	g. **Sitting quietly after lunch without alcohol**	☐	☐	☐	☐
stopped	h. **In a car, while stopped for a few minutes in traffic**	☐	☐	☐	☐
dinner	i. **At the dinner table**	☐	☐	☐	☐
driving	j. **While driving** ☐ N/A-does not drive	☐	☐	☐	☐

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DEMOGRAPHIC INFORMATION

12. Height: _____(feet) _____ (inches)

13. Weight: _____(pounds)

14. Age:_____(years)

15. Gender: ☐ Female ☐ Male

useoxy 16. Do you currently use oxygen or a CPAP or BiLevel machine?
☐ a. Yes
☐ b. No

smoke 17. Do you, and/or anyone living with you, smoke in the room where you sleep?
☐ a. Yes
☐ b. No

YOUR CONTACT INFORMATION

18. Name:_____
First Middle Initial Last

19. Home Phone:_____

20. Cell Phone:_____

21. Work Phone:_____

22. Home Address:_____
Street Apt#

_____
City State Zip

23. Email Address: _____

FOR STUDY STAFF USE ONLY:

BES:_____ ESS:_____