ID						Namecode				

Date			/			/		

Staff ID			

Health Questionnaire

The following questions are about ***your*** health. Please answer each question completely, including the "If No" and "If Yes" parts. If you are unsure of a term or word used, please ask the research assistant for help. All information will be kept strictly confidential and used for medical or research purposes only. Unless otherwise noted, the following questions refer to your sleep and symptoms over the **LAST ONE MONTH**.

SLEEP AND HEALTH HISTORY

1. At what time do you usually FALL ASLEEP on weekdays or your work days?
   ____ ____: ____ ____ ☐☐ A.M. (*Midnight is 12:00 A.M.*) ☐☐ P.M.
   wdfahr wdfamn wdfaap
2. At what time do you usually FALL ASLEEP on weekends or your non-work days?
   ____ ____: ____ ____ ☐☐ A.M. (*Midnight is 12:00 A.M.*) ☐ P.M.
   wefahr wefamn wefaap
3. How many minutes does it usually take you to fall asleep at bedtime?
   _____ _____ _____ (*Number of minutes*)
   asleepmn
4. At what time do you usually WAKE UP on weekdays or your work days?
   ____ ____: ____ ____ ☐☐ A.M. (*Midnight is 12:00 A.M.*) ☐ P.M.
   wdwuhr wdwumn wdwuap
5. At what time do you usually WAKE UP on weekends or your non-work days?
   ____ ____: ____ ____ ☐☐ A.M. (*Midnight is 12:00 A.M.*) ☐ P.M.
   wewuhr wewumn wewuap
6. During a usual week, how many times do you nap for 5 minutes or more? (*Write in "0" if you do not take naps.*)
   _____ _____ (*Number of times*) nap5min

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7. Please indicate how often you experienced the following over the last month.

	NEVER (0)	RARELY (Once a month or less)	SOMETIMES (2-4 times a month)	OFTEN (5-15 times a month)	ALMOST ALWAYS (16-30 times a month)
A. Had trouble falling asleep	trfallaslp ☐☐		☐☐	☐☐	☐☐
B. Woke up during the night and had difficulty getting back to sleep	wokediff ☐☐		☐☐	☐☐	☐☐
C. Woke up too early in the morning and were unable to get back to sleep	wakeearly ☐☐		☐☐	☐☐	☐☐
D. Felt unrested during the day, no matter how many hours of sleep you had	unrested ☐☐		☐☐	☐☐	☐☐
E. Felt excessively (overly) sleepy during the day	excsleepy ☐☐		☐☐	☐☐	☐☐
F. Did not get enough sleep	notenough ☐☐		☐☐	☐☐	☐☐
G. Took sleeping pills or other medications to help you sleep	tookpills ☐☐		☐☐	☐☐	☐☐

bsnore 8. Have you ever snored (now or at any time in the past)?

☐☐ YES ☐ NO → *Skip to Question 10*

☐☐ DON'T KNOW

bsnorefq 9. How often do you snore now? (Check one, thinking about the last month.)

☐ Do not snore anymore
☐☐ Rarely – less than one night a week
☐☐ Sometimes – 1 or 2 nights a week
☐☐ Frequently – 3 to 5 nights a week
☐☐ Always or almost always – 6 or 7 nights a week
☐☐ Don't know

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stopbreath 10. In the last month, were there times when you stopped breathing during your sleep?

☐ YES ☐ NO → *Skip to Question 12*

☐ DON'T KNOW

stopbreathfq 11. In the last month, how often did you have times when you stopped breathing during your sleep? (Check one)

☐ Rarely – less than one night a week
☐ Sometimes – 1 or 2 nights a week
☐ Frequently – 3 to 5 nights a week
☐ Always or almost always – 6 or 7 nights a week
☐ Don't know

snorted 12. In the last month, were there times when you snorted or gasped during your sleep?

☐ YES ☐ NO → *Skip to Question 14*

☐ DON'T KNOW

snortedfq 13. In the last month, how often did you have times when you snorted or gasped during your sleep? (Check one)

☐ Rarely – less than one night a week
☐ Sometimes – 1 or 2 nights a week
☐ Frequently – 3 to 5 nights a week
☐ Always or almost always – 6 or 7 nights a week
☐ Don't know

14. How often, on average in the last month, have you been awakened with the following?

	NEVER (0)	RARELY (Once a month or less)	SOMETIMES (2-4 times a month)	OFTEN (5-15 times a month)	ALMOST ALWAYS (16-30 times a month)
A. Coughing or wheezing	coughing	☐	☐	☐	☐
B. Chest pain or tightness	chestpain	☐	☐	☐	☐
C. Shortness of breath	shortbreath	☐	☐	☐	☐
D. Sweats or hot flashes	sweats	☐	☐	☐	☐
E. Noise in your surroundings	noisesurr	☐	☐	☐	☐
F. Pain in your joints, muscles, or back	painjoints	☐	☐	☐	☐
G. Heartburn or indigestion	heartburn	☐	☐	☐	☐
H. Leg cramps or leg jerks	legcramps	☐	☐	☐	☐
I. Need to go to the bathroom	bathroom	☐	☐	☐	☐

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movelegs 15. In the last month, did you ever experience a desire to move your legs because of discomfort or disagreeable sensations in your legs?

☐ YES ☐ NO → *Skip to Question 16*

☐ DON'T KNOW

IF YES:

moverelieve 15a. 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?

☐ Yes ☐ No ☐ Don't Know

worserest 15b. Are these symptoms worse when you are at rest, with at least temporary relief by activity?

☐ Yes ☐ No ☐ Don't Know

worselater 15c. Are these symptoms worse later in the day or at night? ☐ Yes ☐ No ☐ Don't Know

painwalk 16. In the last month, did you ever get pain in either leg or buttock while walking?

☐ YES ☐ NO → *Skip to Question 17*

IF YES:

painbegin 16a. Does this pain ever begin when you are standing still or sitting? ☐ Yes ☐ No

paincalves 16b. In what part of your leg or buttock do you feel it?
☐ Pain includes calf/calves
☐ Pain does not include calf/calves

walkhurry 16c. Do you get it if you walk uphill or hurry? ☐ Yes ☐ No ☐ N/A

walkordinary 16d. Do you get it if you walk at an ordinary pace on the level? ☐ Yes ☐ No

paindisappear 16e. Does the pain ever disappear while you are walking? ☐ Yes ☐ No

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swelling 17. In the last month, did you have swelling of your feet or ankles? Yes ☐ No ☐ Don't Know ☐

IF YES:

swellingday 17a. Does it tend to come on during the day and go down overnight? ☐ Yes ☐ No ☐ Don't Know

twopillows 18. In the last month, have you had to sleep on two or more pillows to help you breathe? Yes ☐ No ☐ Don't Know ☐

awakened 19. In the last month, have you been awakened at night by trouble breathing? Yes ☐ No ☐ Don't Know ☐

aspirin 20. Have you <u>ever</u> used aspirin on a regular basis? Yes ☐ No ☐ Don't Know ☐

evchestpain

21. Have you <u>ever</u> had any pain or discomfort in your chest? ☐ Yes* ☐ No

22. Have you <u>ever</u> had any pressure or heaviness in your chest? ☐ Yes* ☐ No

evchestpress

***If you answered <u>YES</u> to either of the above questions (21 or 22), answer the below questions (23-27) thinking about the <u>LAST MONTH</u>. If you answered <u>No</u> to both, go to #28:**

presshurry 23. Do you get chest discomfort/pressure when you walk uphill or hurry?
☐ Yes ☐ No ☐ Never hurry or walk uphill

pressordinary 24. Do you get chest discomfort/pressure when you walk at an ordinary pace on ground level?
☐ Yes ☐ No

dopresswalk 25. What do you do if you get chest discomfort/pressure while you are walking?
☐ Stop or slow down ☐ Carry on

standstill 26. If you stand still, what happens to your chest discomfort/pressure?
☐ Relieved ☐ Not relieved (go to #27)

standstillsoon 26a. If **relieved**, how soon? ☐ 10 minutes or less ☐ More than ten minutes

seedoctor 27. Did you see a doctor because of this pain (or discomfort)?
☐ Yes ☐ No

seedoctortext 27a. If **yes**, what did he/she say? _____

allergies 28. Have you <u>ever</u> had allergies to dust, molds, grass or pollen?

☐ Yes ☐ No ☐ Not Sure

allergiestest **IF YES**: 28a. Was this confirmed with a skin test? ☐ Yes ☐ No ☐ Not Sure

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29. Has a doctor ever told you that you had any of the following? Please check the appropriate boxes.

		Yes	No	Don't Know
dxasthma	a. Asthma	☐	☐	☐
dxbronchitis	b. Chronic Bronchitis	☐	☐	☐
dxcopd	c. Emphysema or COPD	☐	☐	☐
dxheartattack	d. Heart Attack	☐	☐	☐
dxhighbp dxhighbpmed dxhighbpage	e. High Blood Pressure or hypertension If YES, 1. Are you taking medicine for this? ☐ Yes ☐ No 2. At what age was this first treated? Age:_____	☐	☐	☐
dxhighchol dxhighcholmed dxhighcholage	f. High Blood Cholesterol If YES, 1. Are you taking medicine for this? ☐ Yes ☐ No 2. At what age was this first treated? Age:_____	☐	☐	☐
dxcarotid	g. Carotid Surgery (Endarterectomy)	☐	☐	☐
dxafib	h. Atrial Fibrillation	☐	☐	☐
dxrheumatic	i. Rheumatic heart disease or heart valve problems	☐	☐	☐
dxbloodclots	j. Blood clots in the lung or in the leg veins	☐	☐	☐
dxstroke	k. Stroke (CVA)	☐	☐	☐
dxtia	l. TIA (Transient Ischemic Attack)	☐	☐	☐
dxpacemaker	m. Implant of Cardiac Pacemaker or Defibrillator	☐	☐	☐
dxdiab dxdiabmed dxdiabmedtype dxdiabmedno dxdiabage dxdiabinsulin	n. Diabetes (sugar in blood) If YES, 1. Are you taking medicine for this? a. ☐ Yes- If yes, what: ☐ Insulin ☐ Pills b. ☐ No- If no, what: ☐ Diet controlled ☐ Nothing 2. At what age was this first treated? Age: _____ 3. Was insulin your first diabetes medicine? ☐ Yes ☐ No ☐ Don't Know	☐	☐	☐

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Continued 29. Has a doctor ever told you that you had any of the following? Please check the appropriate boxes.

		Yes	No	Don't Know
dxcanc	o. Cancer If YES, which type: dxcancpros 1. Prostate Cancer ☐ Yes ☐ No dxcancbreast 2. Breast Cancer ☐ Yes ☐ No dxcanclung 3. Lung Cancer ☐ Yes ☐ No dxcanccolon 4. Colon Cancer ☐ Yes ☐ No dxcancblood 5. Blood Cancer (leukemia, lymphoma, other) ☐ Yes ☐ No dxcancoth 6. Other Cancer: dxcancoth_text ☐ Yes ☐ No	☐	☐	☐
dxsinus	p. Sinus Problems	☐	☐	☐
dxapnea	q. Sleep Apnea	☐	☐	☐
dxinsomnia	r. Insomnia	☐	☐	☐
dxrestlesslegs	s. Restless Legs or Periodic Leg Movements	☐	☐	☐
dxanxiety	t. Anxiety Disorder	☐	☐	☐
dxdepression	u. Depression	☐	☐	☐
dxadhd	v. Attention Deficit Hyperactivity Disorder (ADD/ADHD)	☐	☐	☐
dxliver	w. Liver Disease If YES, which type: dxlivercirr 1. Cirrhosis ☐ Yes ☐ No dxliverhepa 2. Hepatitis ☐ Yes ☐ No dxliveroth 3. Other: dxliveroth_text ☐ Yes ☐ No	☐	☐	☐

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Continued 29. Has a doctor ever told you that you had any of the following? Please check the appropriate boxes.

		Yes	No	Don't Know
dxkidney	x. Kidney Disease specify:___ dxkidney_text _____	☐	☐	☐
dxepilepsy	y. Epilepsy (Seizure Disorder)	☐	☐	☐
dxsclerosis	z. Multiple Sclerosis	☐	☐	☐
dxmigraine	aa. Migraine Headaches	☐	☐	☐
dxarthritis	bb. Rheumatoid Arthritis, Lupus, or other Collagen Vascular Disease	☐	☐	☐
dxbowel	cc. Inflammatory Bowel Disease (Ulcerative Colitis or Crohn's Disease)	☐	☐	☐
dxother1	dd. Other 1: dxother1_text _____	☐	☐	☐
dxother2	ee. Other 2: dxother2_text _____	☐	☐	☐

Have any of the following family members had any of the listed medical conditions (include blood relatives only):

		Yes	No	Don't Know
30. Parents:	30a. Heart Attack	parsheartattack		
	30b. Stroke	parsstroke		☐
	30c. Sleep Apnea	parsapnea		☐
31. Siblings: If you don't have any siblings, please mark this box: ☐ N/A	31a. Heart Attack	sibsheartattack		
	31b. Stroke	sibsstroke		☐
	31c. Sleep Apnea	sibsapnea		☐
32. Children: If you don't have any children, please mark this box: ☐ N/A	32a. Heart Attack	kidsheartattack		
	32b. Stroke	kidsstroke		☐
	32c. Sleep Apnea	kidsapnea		☐

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33. In the **PAST MONTH**, on average, how much time did you spend doing the following activities?

(Enter 0 if you did not do an activity at all)		Amount of Time per Day (hours) (minutes)	Number of Days per Week
a.	Walking for exercise or to school or work	actwalking(hr/mn)	actwalkingdays
b.	Jogging (slower than 10 minutes/mile)	actjogging(hr/mn)	actjoggingdays
c.	Running (10 minutes/mile or faster)	actrunning(hr/mn)	actrunningdays
d.	Bicycling (include stationary machine)	actbicycling(hr/mn)	actbicyclingdays
e.	Tennis, squash, racquetball	acttennis(hr/mn)	acttennisdays
f.	Swimming	actswimming(hr/mn)	actswimmingdays
g.	Other aerobic exercise (aerobic dance, ski or stair machine, etc.)	actaerobic(hr/mn)	actaerobicdays
h.	Lower intensity exercise (yoga, stretching, toning)	actlowint(hr/mn)	actlowintdays
i.	Other vigorous activities (e.g., lawn mowing)	actothvig(hr/mn)	actothvigdays
j.	Weight training or resistance exercises (Include free weights or machines such as Nautilus)	Arm weights: actweightarm(hr/mn) Leg weights: actweightleg(hr/mn)	actweightarmdays actweightlegdays
k.	Other (specify): _____ actother_text _____	actother(hr/mn)	actotherdays

smoked 34. Have you **EVER** smoked cigarettes? ('No' means less than 20 packs in a lifetime or less than 1 cigarette for 1 year)

☐ Yes ☐ No → *Skip to Question 38*

If YES, answer the below questions (35-37):

smokedage 35. How old were you when you first started regular cigarette smoking? _____ years old

smokedfrq 36. On the average, over the entire time you smoked, how many cigarettes did you smoke each day? _____ Cigarettes per day

smokedmonth 37. Over the **last month**, have you smoked at least 1 cigarette per day?

☐ No ☐ Yes

smokedmonthnow 37a. **IF YES**, how many cigarettes do you now smoke each day? _____ Cigarettes per day

smokedmonthstop 37b. **IF NO,** how old were you when you stopped smoking? _____ years old

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caffeine

38. In the last month, how often did you drink beverages containing caffeine (cola, coffee, tea, etc.)?

- ☐ None
- ☐ Less than one cup a day
- ☐ Approximately one cup (8 ozs.) a day
- ☐ More than one cup, less than three cups a day
- ☐ More than three cups a day

alcoholweek

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

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

alcoholoneday

40. 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?

- ☐ 0
- ☐ 1-2
- ☐ 3-5
- ☐ 6-9
- ☐ 10-15
- ☐ 15 or more

alcoholbed

41. When you drink alcohol, do you usually drink during the two hours before bedtime?

☐ Yes ☐ No

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THE FOLLOWING QUESTIONS ARE FOR **WOMEN ONLY**. If you are male, please skip to question 48 on page 12.

menopause 42. Have you gone through menopause or "change of life"?

☐ Yes
☐ No
☐ Don't Know

ovaries 43. Have you had surgery to remove your ovaries?

☐ Yes → If, yes: a. At what age? ovariesage
☐ No b. How many ovaries were removed? ovariesnum
☐ Don't Know

hysterectomy 44. Have you had a hysterectomy (surgery to remove your uterus/womb)?

☐ Yes → If, yes: a. At what age? hysterectomyage
☐ No
☐ Don't Know

period 45. Have you had a menstrual period in the past 12 months?

☐ Yes → If, yes: a. How many periods have you had in the last 12 months? periodnum
☐ No
☐ Don't Know

hormone 46. Are you currently using hormone replacement therapy?

☐ Yes → If yes: a. At what age did you begin? hormoneage

☐ No → If no: a. At what ages did you take hormones?
hormoneagestart Age started_____ Age stopped hormoneagestop
hormonenever ☐ Never took hormone replacement therapy

hormonetype 47. If you were or are taking hormone replacement therapy, which type of therapy was/is it?

☐ Estrogen alone (like Premarin or Estratab)
☐ Estrogen with progestin (like Provera)
☐ Other types of hormone replacement therapy
Please specify: hormonetype_text _____

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DEMOGRAPHICS

48. What is your current employment status (check one)?

employment

- ☐ Working full-time
- ☐ Working part-time
- ☐ Home keeper
- ☐ Unemployed, looking for work
- ☐ Unemployed, not looking for work
- ☐ Student
- ☐ Retired
- ☐ Unable to work because, please specify employment_text

49. Most recent occupation: occupation _____

50. Do you work rotating night shifts? ☐ Yes ☐ No rotatingshifts

51. Do you work steady night shifts? ☐ Yes ☐ No steadyshifts

52. What is your annual household income before taxes?

hhincome

- ☐ Under $5,000
- ☐ $5,000 to $9,999
- ☐ $10,000 to $19,999
- ☐ $20,000 to $29,999
- ☐ $30,000 to $39,999
- ☐ $40,000 to $49,999
- ☐ $50,000 to $59,999
- ☐ $60,000 to $74,999
- ☐ $75,000 to $99,999
- ☐ $100,000 to $149,999
- ☐ $150,000 or more

53. Race (check all that apply):

amerindian
asian
hawaii
black
white
otherrace

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ Black or African American
- ☐ White
- ☐ Other (Please specify): otherrace_text _____

54. Ethnicity:

ethnicity

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino

55. Alternate Contact Person (if we are unable to contact you)

Name: _____

Phone: _____

Address: _____
Street Apt#

_____
City State Zip