

**Multi-Ethnic Study of Atherosclerosis**



**Sleep Questionnaire**

**Participant Id#:**

**Acrostic:**

**Staff ID:**

**Completion Date**

**INSTRUCTIONS:** Enter the response given by the participant for each question. The standard missing value, "=", is allowed for cases where items are permanently missing or 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:

	hr	min	am	pm	
a. On weekdays or work or school days?	<input type="text"/>	<input type="text"/>	:	<input type="text"/>	<input type="text"/>
	<input type="text"/>	<input type="text"/>	:	<input type="text"/>	<input type="text"/>
b. On weekends, or days off?	<input type="text"/>	<input type="text"/>	:	<input type="text"/>	<input type="text"/>
	<input type="text"/>	<input type="text"/>	:	<input type="text"/>	<input type="text"/>

2. What time do you usually wake up:

a. On weekdays or work or school days?	<input type="text"/>	<input type="text"/>	:	<input type="text"/>	<input type="text"/>
	<input type="text"/>	<input type="text"/>	:	<input type="text"/>	<input type="text"/>
b. On weekends, or days off?	<input type="text"/>	<input type="text"/>	:	<input type="text"/>	<input type="text"/>
	<input type="text"/>	<input type="text"/>	:	<input type="text"/>	<input type="text"/>

3. During a usual week, how many times do you nap for 5 minutes or more?

- None
- 1 or more times

(computed as differences b/w wake and bed times)

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 times a week	Yes, 5 or more times a week
4. Did you have trouble falling asleep?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	<input type="text" value="trblespng5"/>				
5. Did you wake up several times a night?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	<input type="text" value="wakeup5"/>				
6. Did you wake up earlier than you planned to?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	<input type="text" value="wakeearly5"/>				
7. Did you have trouble getting back to sleep after you woke up too early?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	<input type="text" value="bcksleep5"/>				
8. Did you take sleeping pills to help you sleep?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	<input type="text" value="slpngpills5"/>				
9. Did you have sleep difficulties that made you very irritable?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	<input type="text" value="irritable5"/>				
10. Did you feel overly sleepy during the day?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	<input type="text" value="sleepy5"/>				

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

typicalslp5

- <sub>0</sub> Very sound or restful
- <sub>1</sub> Sound and restful
- <sub>2</sub> Average quality
- <sub>3</sub> Restless
- <sub>4</sub> Very restless

whiirs5c (sum of 4, 5, 6, 7, and 11)

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. (Mark only one for each item)

		<u>No Chance</u>	<u>Slight Chance</u>	<u>Moderate Chance</u>	<u>High Chance</u>
a. Sitting and reading	readng5	<input type="radio"/> <sub>1</sub>	<input type="radio"/> <sub>2</sub>	<input type="radio"/> <sub>3</sub>	<input type="radio"/> <sub>4</sub>
b. Watching TV	tv5	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. Sitting inactive in a public place (such as a theater or a meeting)	sittng5	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. Riding as a passenger in a car for an hour without a break	riding5	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e. Lying down to rest in the afternoon when circumstances permit	lyngdwn5	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
f. Sitting and talking to someone	talkng5	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
g. Sitting quietly after a lunch without alcohol	quietly5	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
h. In a car, while stopped for a few minutes in traffic	car5	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
i. At the dinner table	dinner5	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
j. While driving	driving5	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

epslp scl5c (sum of items 12a-12h)

13. Over the **past 4 weeks**, how often have you snored? (Mark only one)

snored5

- <sub>1</sub> Never
- <sub>2</sub> Rarely (1-2 nights a week)
- <sub>3</sub> Sometimes (3-5 nights a week)
- <sub>4</sub> Always or almost always (6-7 nights a week)
- <sub>9</sub> Don't know

14. Over the **past 4 weeks**, how often do you have times when you stop breathing during your sleep?

stpbrthng5

- O<sub>1</sub> Never
- O<sub>2</sub> Rarely (1-2 nights a week)
- O<sub>3</sub> Sometimes (3-5 nights a week)
- O<sub>4</sub> Always or almost always (6-7 nights a week)
- O<sub>9</sub> Don't know

15. Do you ever experience a desire to move your legs because of discomfort or disagreeable sensations in your legs?

legsdscmfrt5

If YES:

- O<sub>0</sub> No
- O<sub>1</sub> Yes →
- O<sub>9</sub> Don't know

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

O<sub>0</sub> No  O<sub>1</sub> Yes  O<sub>9</sub> Don't know

rubbnglgs5

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

O<sub>0</sub> No  O<sub>1</sub> Yes  O<sub>9</sub> Don't know

wrserest5

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

O<sub>0</sub> No  O<sub>1</sub> Yes  O<sub>9</sub> Don't know

wrseltr5

16. Considering only your own "feeling best" rhythm, at what time would you get up if you were entirely free to plan your day?

feelngbstr5

- O<sub>1</sub> 5:00 - 6:30 am
- O<sub>2</sub> 6:30 - 7:45 am
- O<sub>3</sub> 7:45 - 9:45 am
- O<sub>4</sub> 9:45 - 11:00 am
- O<sub>5</sub> After 11:00 am

17. During the first half hour after having woken in the morning, how tired do you feel?

tired5

- O<sub>1</sub> Very tired
- O<sub>2</sub> Fairly tired
- O<sub>3</sub> Fairly refreshed
- O<sub>4</sub> Very refreshed

18. At what time in the evening do you feel most tired and, as a result, most in need of sleep?

mosttired4

- O<sub>1</sub> 8:00 - 9:00 pm
- O<sub>2</sub> 9:00 - 10:15 pm
- O<sub>3</sub> 10:15 - 12:45 am
- O<sub>4</sub> 12:45 - 2:00 am
- O<sub>5</sub> After 2:00 am

19. At what time of the day do you think that you reach your "feeling best" peak?

<sub>1</sub> 5:00 - 8:00 am

<sub>4</sub> 4:45 - 9:45 pm

feelngbstpk5

<sub>2</sub> 8:00 - 10:00 am

<sub>5</sub> After 9:45 pm

<sub>3</sub> 10:00 - 4:45 pm

20. One hears about "morning" and "evening" types of people. Which ONE of these types do you consider yourself to be?

<sub>1</sub> Definitely a "morning" type

types5

<sub>2</sub> Rather more a "morning" than an "evening" type

<sub>3</sub> Rather more an "evening" than a "morning" type

<sub>4</sub> Definitely an "evening" type

<sub>5</sub> NEITHER a "morning" or an "evening" type

hoostmeq5c (sum of  
16-20 w/ reverse coding)

21. Have you been told by a doctor that you have any of the following:

a. Sleep Apnea (or obstructive sleep apnea, OSA)?

slpapnea5

<sub>0</sub> No

<sub>1</sub> Yes

If YES:

Did you receive treatment for sleep apnea with any of the following?

CPAP or BIPAP machine

cpap5

Dental (oral) device

dntaldv5

Throat/Uvula surgery

uvula5

b. Insomnia?

<sub>0</sub> No

<sub>1</sub> Yes

insmnia5

c. Restless Legs?

<sub>0</sub> No

<sub>1</sub> Yes

rstlesslgs5

22. Which of the following best describes your usual work schedule? (Mark only one)

wrksched5

<sub>1</sub> Day shift

<sub>5</sub> Irregular shift/On-call

<sub>2</sub> Afternoon shift

<sub>6</sub> Rotating shifts

<sub>3</sub> Night shift

<sub>7</sub> Don't work → End Form

<sub>4</sub> Split shift

23. How many days per month do you work extra hours beyond your usual schedule?

extrahrs5

number of days