

# Enrollment Form

Office Use Only--  
MrOS ID#

Acrostic

Staff ID#

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1 Is participant willing to complete the MrOS Sleep Visit?

Yes

No →

Reason:

- Not interested/Too busy
- Health Problems
- Out of Area
- Too many contacts from study
- Caregiver responsibilities
- Postcard Only status (not contacted)
- Other \_\_\_\_\_

VS21FUTM VS22FUTM  
 VS2DFUTM VS23FUTM  
 VS2IFUTM VS2I2FUTM  
 VS2SFUTM

VS21FYTM VS22FYTM  
 VS2DFYTM VS23FYTM  
 VS2IFYTM VS2I2FYTM  
 VS2SFYTM

## SCREENING QUESTIONS:

A. Do you have an open tracheostomy?

Yes  No

**NOT ELIGIBLE - SKIP TO QUESTION D**

B. In the past three months, have you used any of the following items? (Mark all that apply)

-1  Pressure mask ("CPAP" or "BiPAP" for sleep apnea)  
 VS2CPAP

When do you usually wear it?

- During sleep and wake
- During sleep only
- During wake only

VS2CPAP1

-1  Mouthpiece (for snoring)

VS2MPIECE

When do you usually wear it?

- During sleep and wake
- During sleep only
- During wake only

VS2MPIEC1

**NOTE:** Please ensure that the participant has not had any active respiratory symptoms (exacerbation, new cough, or wheezing), obvious respiratory distress or recent onset of chest pains in the past two weeks. If so, please reschedule visit in two weeks.

-1  Oxygen therapy

VS2OXTHER

When do you usually wear it?

- During sleep and wake
- During sleep only
- During wake only

VS2OXTHE1

-1  None

VS2ESNONE

C. Is participant eligible for actigraphy?

Yes  No

D. Did participant complete the MrOS Sleep visit?

Yes  Not eligible

a. Date of visit:

		/			/				
Month			Day			Year			

VS2SLDATE

VS2SLSAQ

b. Who completed the SAQ?  Participant  Spouse  Other family  Clinic  Other

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# Sleep History

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1 How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently try to think about out how they would have affected you. Give the most appropriate response for each situation.

**EPEPWORT**    **EPEDS**    Never Doze    Slight Chance of Dozing    Moderate Chance of Dozing    High Chance of Dozing

a. Sitting and reading <b>EPREAD</b>	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
b. Watching TV <b>EPTV</b>	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
c. Sitting inactive in a public place (e.g. a theater or a meeting) <b>EPPUB</b>	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
d. As a passenger in a car for an hour without a break <b>EPCAR</b>	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
e. Lying down to rest in the afternoon when circumstances permit <b>EPREST</b>	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
f. Sitting and talking to someone <b>EPTALK</b>	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
g. Sitting quietly after a lunch without alcohol <b>EPEAT</b>	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
h. In a car, while stopped for a few minutes in traffic <b>EPTRAF</b>	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3

2 Do you ever experience a desire to move your legs or arms because of discomfort or disagreeable sensations in your legs or arms? **SLRLDES**

Yes     No     Don't know

a. 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    **SLRLRELV**

b. Are these symptoms worse when you are at rest (i.e., sitting quietly), with at least temporary relief by activity?  
 Yes     No     Don't know    **SLRLREST**

c. Are these symptoms worse later in the day or at night, than in the morning?  
 Yes     No     Don't know    **SLRLLATR**

(If participant answers 'Yes' to 2a, have him answer the questions from the Restless Legs Syndrome Rating Scale on the following page)





# Restless Legs Syndrome Rating Scale

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C	C	S	T	A	F	F
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Instructions: If participant answers 'Yes' to 2a on the previous page, have him rate his symptoms for the following questions. The examiner should mark his answers on the form and clarify any misunderstandings he may have about the questions.

Was the Restless Legs Syndrome Rating Scale administered?  Yes  No **SLRLSADM**

**SLRLWHYN**

Why not?  Not required  Refused  Other

- 1 In the PAST MONTH, overall, how would you rate the RLS discomfort in your legs or arms?  
 Very Severe  Severe  Moderate  Mild  None **SLRLDISC**
- 2 In the PAST MONTH, overall, how would you rate the need to move around because of your RLS symptoms?  
 Very Severe  Severe  Moderate  Mild  None **SLRLMOV**
- 3 In the PAST MONTH, overall, how much relief of your RLS arm or leg discomfort did you get from moving around?  
 No relief  Mild relief  Moderate relief  Complete or almost complete relief  Does not apply **SLRLREL**
- 4 In the PAST MONTH, how severe is your sleep disturbance due to your RLS symptoms?  
 Very Severe  Severe  Moderate  Mild  None **SLRLSLPD**
- 5 In the PAST MONTH, how severe is your tiredness or sleepiness during the day due to your RLS symptoms?  
 Very Severe  Severe  Moderate  Mild  None **SLRLTIRE**
- 6 In the PAST MONTH, how severe was your RLS as a whole?  
 Very Severe  Severe  Moderate  Mild  None **SLRLSYMP**
- 7 In the PAST MONTH, how often did you get RLS symptoms? **SLRLOFTN**  
 6-7 days a week  4-5 days a week  2-3 days a week  1 day a week or less  Never
- 8 In the PAST MONTH, when you had RLS symptoms, how severe were they on average? **SLRLSEVR**  
 8 hours per day or more  3-8 hours per day  1-3 hours per day  1 hour per day  None
- 9 In the PAST MONTH, overall, how severe is the impact of your RLS symptoms on your ability to carry out your daily affairs, for example carrying out a satisfactory family, home, social, or work life?  
 Very Severe  Severe  Moderate  Mild  None **SLRLAFFR**
- 10 In the PAST MONTH, how severe was your mood disturbance due to your RLS symptoms- for example angry, depressed, sad, anxious, or irritable?  
 Very Severe  Severe  Moderate  Mild  None **SLRLMOOD**

**SLRLSCOR**  
**SLRLSCAT**





# Insomnia Severity Index

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For each question below, please choose the answer corresponding most accurately to your sleep patterns in the LAST MONTH.

For the first three questions, please rate the SEVERITY of your sleep difficulties.

- ① **Difficulty falling asleep: SLFALSLP**  
 5 None  4 Mild  3 Moderate  2 Severe  1 Very Severe
- ② **Difficulty staying asleep: SLSTYSLP**  
 5 None  4 Mild  3 Moderate  2 Severe  1 Very Severe
- ③ **Problem waking up too early in the morning: SLWKERLY**  
 5 None  4 Mild  3 Moderate  2 Severe  1 Very Severe
- ④ **How SATISFIED/DISSATISFIED are you with your current sleep pattern?**  
 0 Very Satisfied  1 Satisfied  2 Neutral  3 Dissatisfied  4 Very Dissatisfied  
**SLSATPAT**

These next questions ask about any potential sleep problems you may have had in the LAST MONTH.

- ⑤ **To what extent do you consider your sleep problem to INTERFERE with your daily functioning (e.g., daytime fatigue, ability to function at work/daily chores, concentration, memory, mood, etc.)?**
- |                 |                           |                         |                         |                         |                          |
|-----------------|---------------------------|-------------------------|-------------------------|-------------------------|--------------------------|
|                 | Not at all<br>interfering | A little<br>interfering | Somewhat<br>interfering | Much<br>interfering     | Very much<br>interfering |
| <b>SLPRINTR</b> | <input type="radio"/> 0   | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 | <input type="radio"/> 4  |
- ⑥ **How NOTICEABLE to others do you think your sleeping problem is in terms of impairing the quality of your life?**
- |                 |                          |                         |                         |                         |                         |
|-----------------|--------------------------|-------------------------|-------------------------|-------------------------|-------------------------|
|                 | Not at all<br>noticeable | A little<br>noticeable  | Somewhat<br>noticeable  | Much<br>noticeable      | Very much<br>noticeable |
| <b>SLPRNOTC</b> | <input type="radio"/> 0  | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 | <input type="radio"/> 4 |
- ⑦ **How WORRIED/DISTRESSED are you about your sleep problem?**  
 0 Not at all  1 A little  2 Somewhat  3 Much  4 Very Much **SLPRWORR**

SLISISCR  
SLISICAT





# Fatigue Scale

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① This next question refers to the past month. In the past month, on the average, have you been feeling unusually tired during the day?

*SLTIRE*

Yes   
  No   
  Don't know   
  Refused

Have you been feeling unusually tired...? <i>SLOFTN</i> <input type="radio"/> All of the time <input type="radio"/> Most of the time <input type="radio"/> Some of the time <input type="radio"/> Don't know
---

② During the past month, how weak did you feel? Using this card, please choose the best category, where 0 is "not weak at all" and 10 is "very weak."

0     1     2     3     4     5     6     7     8     9     10   
  11 Don't Know     12 Refused

*SLWKLEV*

③ During the past month, how sleepy did you feel during the day? Using this card, please choose the best category, where 0 is "not sleepy at all" and 10 is "very sleepy."

0     1     2     3     4     5     6     7     8     9     10   
  11 Don't Know     12 Refused

*SLSLPLEV*

④ During the past month, how lively did you feel? Using this card, please choose the best category, where 0 is "not lively at all" and 10 is "very lively."

0     1     2     3     4     5     6     7     8     9     10   
  11 Don't Know     12 Refused

*SLLIVLEV*

⑤ During the past month, how tired did you feel? Using this card, please choose the best category, where 0 is "not tired at all" and 10 is "very tired."

0     1     2     3     4     5     6     7     8     9     10   
  11 Don't Know     12 Refused

*SLTIRLEV*

⑥ Using this card, please choose the category that best describes your usual energy level in the past month on a scale of 0 to 10 where 0 is "no energy" and 10 is "the most energy" that you have ever had.

0     1     2     3     4     5     6     7     8     9     10   
  11 Don't Know     12 Refused

*SLENRLEV*

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The following questions are about how well you are able to do certain activities, by yourself and without using any special aids.

① Do you have ANY difficulty walking 2 or 3 blocks outside on level ground?

QLBLK1  
QLBLK2  
QLRBLK1

Yes  No

GO TO QUESTION #2

I don't do it QLBLK

QLBLK1VL  
How much difficulty do you have doing this?  
 Some difficulty  Much difficulty  Unable to do it

Is this because of a health or physical problem? QLBLKPRB  
 Yes  No  I don't know

② Do you have ANY difficulty climbing up 10 steps without resting?

QLSTP1  
QLSTP2  
QLRSTP1

Yes  No

GO TO QUESTION #3

I don't do it QLSTP

QLSTP1VL  
How much difficulty do you have doing this?  
 Some difficulty  Much difficulty  Unable to do it

Is this because of a health or physical problem? QLSTPPRB  
 Yes  No  I don't know

③ Do you have ANY difficulty preparing your own meals?

QLMEL1  
QLMEL2  
QLRMEL1

Yes  No

GO TO QUESTION #4

I don't do it QLMEL

QLMEL1VL  
How much difficulty do you have doing this?  
 Some difficulty  Much difficulty  Unable to do it

Is this because of a health or physical problem? QLMELPRB  
 Yes  No  I don't know

④ Do you have ANY difficulty doing heavy housework, like scrubbing floors or washing windows?

QLHHW1  
QLHHW2  
QLRHHW

Yes  No

GO TO QUESTION #5

I don't do it QLHHW

QLHHW1VL  
How much difficulty do you have doing this?  
 Some difficulty  Much difficulty  Unable to do it

Is this because of a health or physical problem? QLHHWPRB  
 Yes  No  I don't know

⑤ Do you have ANY difficulty doing your own shopping for groceries or clothes?

QLSHP1  
QLSHP2  
QLRSHP1

Yes  No

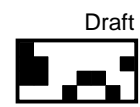
GO TO QUESTION #6

I don't do it QLSHP

QLSHP1VL  
How much difficulty do you have doing this?  
 Some difficulty  Much difficulty  Unable to do it

Is this because of a health or physical problem? QLSHPPRB  
 Yes  No  I don't know

QLFXST51  
QLFXST52







# Functional Status

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The following questions are about how well you are able to do certain activities, by yourself and without using any special aids.

6 Do you have ANY difficulty managing money?

Yes  No

GO TO QUESTION #7

How much difficulty do you have doing this?  
 Some difficulty  Much difficulty  Unable to do it

QLMONLVL

I don't do it QLMON

QLMON1  
QLMON2  
QLRMON1

Is this because of a health or physical problem?  
 Yes  No  I don't know

QLMONPRB

QLBAT1  
QLBAT2  
QLRBAT1

7 Do you have ANY difficulty bathing or showering?

Yes  No

GO TO QUESTION #8

How much difficulty do you have doing this?  
 Some difficulty  Much difficulty  Unable to do it

QLBATLVL

I don't do it QLBAT

Is this because of a health or physical problem?  
 Yes  No  I don't know

QLBATPRB

QLBED1  
QLBED2  
QLRBED1

8 Do you have ANY difficulty getting in and out of beds or chairs?

Yes  No

GO TO QUESTION #9

How much difficulty do you have doing this?  
 Some difficulty  Much difficulty  Unable to do it

QLBEDLVL

I don't do it QLBED

Is this because of a health or physical problem?  
 Yes  No  I don't know

QLBEDPRB

9 Do you have ANY difficulty managing your medications?

Yes  No

GO TO NEXT SECTION

How much difficulty do you have doing this?  
 Some difficulty  Much difficulty  Unable to do it

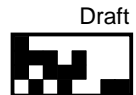
QLMEDLVL

I don't do it QLMED

Is this because of a health or physical problem?  
 Yes  No  I don't know

QLMEDRB

QLMED1  
QLMED2  
QLRMED1





# Teng Mini-Mental

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Introduction: 'Are you comfortable? I would like to ask you a few questions that require concentration and memory. Some are a little bit more difficult than others. Some questions will be asked more than once.'

A. Was the Mini-Mental test administered?  Yes  No →

*TMTTEST*

Why not?

Refused  Other: *TMWHYN*

B. What time was the Mini-Mental test administered (start time)?

*TMTIMEM*

 : 

A.M.

P.M.

1 A. When were you born?

 /  / 

Month

Day

Year

B. Where were you born? Place of Birth?

Answer given\*  Can't do/Refused  Not attempted

City or town

State/Country

\* If answer is given, you will ask again in question #18

2 I am going to say three words for you to remember. Repeat them after I have said all three words:

Shirt, Blue, Honesty

Do not repeat the words for the participant until after the first trial. The participant may give the words in any order. If there are errors on the first trial, repeat the items up to six times until they are learned.

Correct  Error/Refused  Not attempted

A. Shirt

B. Blue

C. Honesty

D. Number of presentations necessary for the participant to repeat the sequence

*CJTMNUM*  
presentations

3 A. I would like you to count from 1 to 5.

Able to count forward

Unable to count forward

↓  
Say "1,2,3,4,5"

B. Now I would like you to count backwards from 5 to 1.

Record the response in the order given. Enter 99999 if no response.

4 A. Spell 'world'.

Able to spell

Unable to spell

↓  
Say "Its spelled W-O-R-L-D"

B. Now spell world backwards

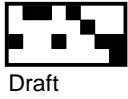
    

Record the response in the order given. Enter XXXXX if no response.

SEE PAGE 11 FOR SCORING VARIABLES







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5 What three words did I ask you to remember?

**A. Shirt**

- Spontaneous recall
- Correct word, incorrect form
- After 'Something to wear'
- After 'Shirt, shoes, socks'
- Unable to recall/refused
- Not attempted

**B. Blue**

- Spontaneous recall
- Correct word, incorrect form
- After 'A color'
- After 'Blue, black, brown'
- Unable to recall/refused
- Not attempted

**C. Honesty**

- Spontaneous recall
- Correct word, incorrect form
- After 'A good personal quality'
- After 'Honesty, charity, modesty'
- Unable to recall/refused
- Not attempted

6 A. What is today's date?

		/			/				
Month			Day			Year			

B. What is the day of the week?

- Correct
- Error/Refused \_\_\_\_\_ day of the week
- Not attempted

C. What season of the year is it?

- Correct
- Error/Refused \_\_\_\_\_ season
- Not attempted

7 A. What state are we in?

- Correct
- Error/Refused \_\_\_\_\_ state
- Not attempted

B. What county are we in?

- Correct
- Error/Refused \_\_\_\_\_ county
- Not attempted

C. What city/town are we in?

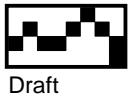
- Correct
- Error/Refused \_\_\_\_\_ city/town
- Not attempted

D. Are we in a clinic, store, or home?

- Correct
- Error/Refused \_\_\_\_\_
- Not attempted

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8 Point to the object or part of your own body and ask the participant to name it. Score 'Error/Refused' if the participant cannot name it within 2 seconds or gives an incorrect name.

	Correct	Error/ Refused	Not attempted
A. Pencil: 'What is this?'	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
B. Watch: 'What is this?'	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
C. Forehead: 'What do you call this part of the face?'	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
D. Chin: 'And this part?'	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
E. Shoulder: 'And this part of the body?'	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F. Elbow: 'And this part?'	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
G. Knuckle: 'And this part?'	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

9 What animals have four legs? Tell me as many as you can.

Discontinue after 30 seconds. If the participant gives no response in 10 secs and there are at least 10 secs remaining, gently remind them (once only): 'What (other) animals have four legs?'. The first time an incorrect answer is provide, say 'I want four-legged animals.' Do not correct for subsequent errors.

Score (total correct responses)

--	--

Record correct responses:

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Record additional correct answers on a separate sheet

10

A. In what way are an arm and a leg alike?

- Limbs, extremities, appendages
- Lesser correct answer (e.g., body parts, both bend, have joints)
- Error/Refused
- Not attempted

B. In what way are laughing and crying alike?

- Expressions of feelings, expressions of emotions
- Lesser correct answer (e.g., sounds, expressions, emotions, or other similar responses)
- Error/Refused
- Not attempted

C. In what way are eating and sleeping alike?

- Necessary bodily functions, essential for life
- Lesser correct answer (e.g., bodily functions, relaxing, 'good for you' or other similar responses)
- Error/Refused
- Not attempted

11

Repeat what I say: 'I would like to go out.'

- Correct
- 1 or 2 words missed
- 3 or more words missed
- Not attempted

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12 Now repeat: 'No ifs, ands or buts.'

	Correct	Error/ Refused	Not attempted
A. no ifs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
B. ands	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
C. or buts	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

13 Hold up Card #1 and say: 'Please do this.'

If participant does not close their eyes within 5 secs, prompt by pointing to the card and saying 'Read and do what this says.'

- Closes eyes without prompting
- Closes eyes after prompting
- Reads aloud, but does not close eyes
- Does not read aloud or close eyes/Refused
- Not attempted

14 Please write the following sentence: I would like to go out.

	Correct	Error/ Refused	Not attempted
A. would	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
B. like	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
C. to	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
D. go	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
E. out	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Which hand does the participant use to write? If task not done, ask if they are right or left handed.

- 1  Right    2  Left    3  Unknown

TMHAND

15 Here is a drawing. Please copy the drawing onto this piece of paper.

**A. Pentagon 1**

- 5 approximately equal sized sides
- 5 sides, but longest:shortest side is >2:1
- Nonpentagon enclosed figure
- 2 or more lines, but it is not an enclosed figure
- Less than 2 lines, Refused
- Not attempted

**B. Pentagon 2**

- 5 approximately equal sized sides
- 5 sides, but longest:shortest side is >2:1
- Nonpentagon enclosed figure
- 2 or more lines, but it is not an enclosed figure
- Less than 2 lines, Refused
- Not attempted

**C. Intersection**

- 4-cornered enclosure
- Not a 4-cornered enclosure
- No enclosure, Refused
- Not attempted, Disabled

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- 16** Refer to Question 14 to check whether the participant is right or left-handed.  
**Take this paper with your left hand (right for left-handed person), fold it in half using both hands, and hand it back to me.**
- |                                | Correct               | Error/<br>Refused     | Not<br>attempted      |
|--------------------------------|-----------------------|-----------------------|-----------------------|
| A. Takes paper in correct hand | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| B. Folds paper in half         | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| C. Hands paper back            | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

- 18** Would you please tell me again where you were born?
- |                     | Matches               | Does not<br>match/<br>Refused | Not<br>attempted      |
|---------------------|-----------------------|-------------------------------|-----------------------|
| _____ City or town  | <input type="radio"/> | <input type="radio"/>         | <input type="radio"/> |
| _____ State/Country | <input type="radio"/> | <input type="radio"/>         | <input type="radio"/> |

- 17** What three words did I ask you to remember earlier?

**A. Shirt**

- Spontaneous recall
- Correct word, incorrect form
- After 'Something to wear'
- After 'Shirt, shoes, socks'
- Unable to recall/refused
- Not attempted

**B. Blue**

- Spontaneous recall
- Correct word, incorrect form
- After 'A color'
- After 'Blue, black, brown'
- Unable to recall/refused
- Not attempted

**C. Honesty**

- Spontaneous recall
- Correct word, incorrect form
- After 'A good personal quality'
- After 'Honesty, charity, modesty'
- Unable to recall/refused
- Not attempted

- 19** Please indicate if the participant has any physical/functional disabilities or other problems which made it difficult or impossible to complete any of the tasks above. Check all that apply.

- Vision **1 TMDIFFVI**
- Hearing **1 TMDIFFHE**
- Writing problems due to injury or illness **1 TMDIFFWR**
- Illiteracy/Lack of education **1 TMDIFFIL**
- Language **1 TMDIFFLA**
- Other: **1 TMDIFFOT**

**TMMFLAG**  
**TMBDAY**  
**TMREGIS**  
**TMREVERS**  
**TMRECALL**  
**TMTEMPUR**  
**TMSPACE**  
**TMNAMING**  
**TM4LEG**  
**TMMSCORE**

**TMM1SSCR**

**TMM1S2SC**  
**TMMSS2SC**  
**TMM2S2SC**  
**TMM3S2SC**

Draft





# Trail Making Task B & DVT

Office Use Only--  
MrOS ID#

Acrostic

Trails B Staff ID#

1 Was the participant able to complete the Sample Response Sheet?  Yes  No **TBSAMP**

Why not?  Unable due to physical problems (hand tremor, cast, etc.)  Other **TBWHYN**  
 Participant did not understand directions  Participant Refused

2 Was the Trails B test administered?  Yes  No →  Did not complete sample test  Refused  Other  
**TBTEST** **TBTEWHYN**

What time was the Trails B test administered (start time)?  :   A.M.  P.M. **TBTIMEM**

Number of circles connected (maximum=25):  circles **TBCIRCLE**  
Total time (max=300 seconds or 5 minutes):  secs **TBSECON**  
# of errors made by participant (max=5):  errors **TBERROR**

Please note: If secs<300, circles=25. If errors=5, secs=300

Is the hand being used to complete Trails B the participant's usual or dominant hand for writing?  Yes  No **TBDOMH**

Are there any peripheral injuries (e.g., crushed or missing fingers, broken bones in the hand) or other things that have occurred in the participant's life history that would adversely affect their ability to do the test?  Yes  No **TBAFFECT**

Did the participant have a hand tremor (dominant hand)?  No  Mild  Marked **TBTREM**

## Digit Vigilance Test

DVT Staff ID#

1 Did participant complete the sample vigilance test?  Yes  No **DVVIGIL**

Why not? **DVVIGNO**  
 Unable  Did not understand directions  Other  Refused

2 Did participant complete page 1 in <400 seconds (6 minutes 40 seconds)?  Yes  No **DVVIGPG1**

If NO, Do NOT have participant complete page 2. Record time and errors for page 1 ONLY below.

3 Total Time:  seconds **DVTIME**

NOTE: If both pages completed record TOTAL time and errors.

4 Omission Errors:  errors **DVOMERR**  
Commission Errors:  errors **DVCOMERR**

**DVTOTERR**

### Minutes/Seconds to Second Conversions

Minutes	Seconds	Minutes	Seconds
1:00	60	5:00	300
1:15	75	5:15	315
1:30	90	5:30	330
1:45	105	5:45	345
2:00	120	6:00	360
2:15	135	6:15	375
2:30	150	6:30	390
2:45	165	6:40	400
3:00	180	6:45	405
3:15	195	7:00	420
3:30	210	7:15	435
3:45	225	7:30	450
4:00	240	7:45	465
4:15	255	8:00	480
4:30	270	8:15	495
4:45	285	8:30	510





# Grip Strength

Office Use Only-- MrOS ID#					Acrostic			Staff ID#		
								GS	STAFF	

## EXCLUSION CRITERIA:

1 Has any pain or arthritis in your hands gotten worse recently?

Yes  No  Refused  Don't Know **GSWEAK**

Which side?	<input type="radio"/> Left	<input type="radio"/> Right	<input type="radio"/> Both	<b>GSSDWEAK</b>
	<b>DO NOT TEST LEFT</b>	<b>DO NOT TEST RIGHT</b>	<b>DO NOT TEST EITHER SIDE</b>	

2 Have you had any surgery on your hands or wrists in the past 3 months (12 weeks)?

Yes  No **CQGSSURG**

Which side?	<input type="radio"/> Left	<input type="radio"/> Right	<input type="radio"/> Both	<b>GSSDSURG</b>
	<b>DO NOT TEST LEFT</b>	<b>DO NOT TEST RIGHT</b>	<b>DO NOT TEST EITHER SIDE</b>	

**GSFLAGEX**

3

### Right side

Trial 1   **GSRT1** kg  
 Refused  
 Unable, did not attempt

Trial 2   **GSRT2** kg  
 Refused  
 Unable, did not attempt

**GSGRPRAV**

**GSGRPAVG**  
**GSGRPMAX**

**GSGRPLAV**

**GS1S2AVS**  
**GSDS2AVS**  
**GSSS2AVS**  
**GS2S2AVS**  
**GS3S2AVS**

4

### Left side

Trial 1   **GSLF1** kg  
 Refused  
 Unable, did not attempt

Trial 2   **GSLF2** kg  
 Refused  
 Unable, did not attempt

**GS1S2GSP**  
**GSDS2GSP**  
**GSSS2GSP**  
**GS2S2GSP**  
**GS3S2GSP**



# Chair Stands

Office Use Only--						Acrostic			Staff ID#		
MrOS ID#						ACROST			NFCSTAFF		

## INTRODUCTION/SCREENING QUESTIONS

- 1 Ask the participant: **Do you use any walking aids, such as a cane?** *NFAIDS*  
 1  No aids    2  Cane or quad cane    3  Walker, wheelchair, leg brace, crutches
- 2 Does the participant have any of the following? If you are uncertain about one of following conditions, ask the participant. (Mark all that apply)  
 1 *NFORTH*  Orthosis     Missing limbs    1 *NFPROTHE*  Prosthesis     Paralysis of extremity or side of body  
 1 *NFLIMB*    1 *NFPARALY*
- 3 Ask the participant: **Do you have any problems from recent surgery, injury or other health conditions that might prevent you from standing straight up from a chair or walking quickly?**

*NFPROB*    1  Yes     No

Tell the participant: "Before we do each test, I'll describe it to you. Please tell me if you think that you shouldn't attempt the test because of the problems you described."

## SINGLE CHAIR STAND

- 4 Could the participant stand up one time unassisted? *NFSTAND1*  
 1  Yes    2  No, unable to stand    3  No, rises using arms    7  Did not attempt/Refused

Do **NOT** perform Repeat Chair Stands. Go on to Six Meter Usual Pace

## REPEATED CHAIR STANDS

- 5 Did the participant complete all 5 stands?

1  Yes    0  No    *NF5STAND*

Time to complete stands? *NFTIME5*   .   seconds

Record arm use: 1  Did not use arms  
 2  Used arms part of the time    3  Used arms all of the time

*NFARMU5A*

How many chair stands were completed? *NF5MANY*  stands

Why weren't 5 chair stands completed?  
 4  Attempted, but unable to stand once without help  
 5  Completed at least 1 stand, but unable to complete 5 without help  
 7  Did not attempt/refused    *NFARMU5B*

*NFSTDARM*

Draft







# Walking Tests

Office Use Only--

MrOS ID#

Acrostic

Staff ID#

--	--	--	--	--	--

--	--	--	--	--	--

N	F	W	S	T	A	F	F
---	---	---	---	---	---	---	---

## SIX METER USUAL PACE

1 Did the participant complete Trial 1? **NFWLKNA1**

1  Yes 2  No, participant attempted but unable 3  No, unable to assess

NFSTPLGT  
NFWLKSPD  
NF6MWTM  
NF6MPACE

Record time and number of steps:

--	--

**NFWLKTM1**  
seconds

--	--

**NFWLKST1**  
steps

Aid used:  No aid 1  Straight cane 2  Quad cane 3  Walker 4  Crutch

NF1S2STL  
NFDS2STL  
NFSS2STL  
NF2S2STL  
NF3S2STL

2 Did the participant complete Trial 2?

1  Yes 2  No, participant attempted but unable 3  No, unable to assess

NF1S26MP  
NFDS26MP  
NFSS26MP  
NF2S26MP  
NF3S26MP

Record time and number of steps:

--	--

**NFWLKTM2**  
seconds

--	--

**NFWLKST2**  
steps

Aid used:  No aid 1  Straight cane 2  Quad cane 3  Walker 4  Crutch

NF1S26MT  
NFDS26MT  
NFSS26MT  
NF2S26MT  
NF3S26MT

NFNWTIME  
NFNWPACE  
NFPCTDIF  
NDFSCOR  
NFNWNUM

## NARROW WALK

Did the participant successfully stay within the lines on Trial 1 (have 2 or less deviations)?

1  Yes 0  No, 3 or more deviations/Unable to complete 2  No, trial not attempted

**NFNWKNA1**

Record time:

--	--	--	--

**NFNWKT1**  
seconds

Aid used:  No aid

**NFNWLKA1**

1  Straight cane 2  Quad cane 3  Walker 4  Crutch

4 Did the participant successfully stay within the lines on Trial 2 (have 2 or less deviations)?

1  Yes 0  No, 3 or more deviations/Unable to complete 2  No, trial not attempted

**NFNWKNA2**

Record time:

--	--	--	--

**NFNWKT2**  
seconds

Aid used:  No aid

**NFNWLKA2**

1  Straight cane 2  Quad cane 3  Walker 4  Crutch

NF1S2NWT  
NFDS2NWT  
NFSS2NWT  
NF2S2NWT  
NF3S2NWT

Perform trial 3 only if trial 1 or trial 2 were marked 'No, 3 or more deviations/Unable to complete'

5 Did the participant successfully stay within the lines on Trial 3 (have 2 or less deviations)?

1  Yes 0  No, 3 or more deviations/Unable to complete 2  No, trial not attempted

**NFNWKNA3**

Record time:

--	--	--	--

**NFNWKT3**  
seconds

Aid used:  No aid

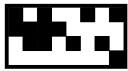
**NFNWLKA3**

1  Straight cane 2  Quad cane 3  Walker 4  Crutch

NF1S2NWP  
NFDS2NWP  
NFSS2NWP  
NF2S2NWP  
NF3S2NWP

NF1S2PDF  
NFDS2PDF  
NFSS2PDF  
NF2S2PDF  
NF3S2PDF





Draft

# Spirometry

Office Use Only--  
MrOS ID#

--	--	--	--	--	--	--	--

Acrostic

--	--	--	--	--	--	--	--

Spirometry Staff ID#

SR	ST	AF	FF
----	----	----	----



NOTE: Please ensure that the participant has not had any active respiratory symptoms (exacerbation, new cough, or wheezing), obvious respiratory distress, or recent onset of chest pains in the past two weeks. If so, please reschedule visit in two weeks.

## 1 SPIROMETRY EXCLUSION CRITERIA:

a. Have you had a heart attack, a stroke, or eye surgery in the past three months?

Yes  No *SRHRTEYE*

**NOT ELIGIBLE**

b. Do you have any of the following problems: coughing up blood; a past history of an air leak in your lungs; or past history of an aneurysm in your chest?

Yes  No *SRHEMOPT*

**NOT ELIGIBLE**

c. Have you had any significant problems doing spirometry in the past?

Yes  No  Don't Know *SRPROBLM*

Please describe: \_\_\_\_\_ If the problem was indeed significant and likely to recur with retesting, participant is NOT ELIGIBLE. DO NOT PROCEED with spirometry measurements.

2 Did the participant complete the spirometry test?  Yes  No *SRSPIRO*

VS2SR
VS2SRRSN

Why not?  Refused  Not eligible  Physical/Medical Problem  Equipment Problem  Other *SRWHYN*

## 3 PRE-TEST:

a. Did you smoke within the last two hours?  Yes  No *SRSMOKE2*

b. Did you use an inhaled bronchodilator within the last four hours?  Yes  No *SRBRONC4*

c. Have you had a cold or minor respiratory illness (not listed above) in the last two weeks (i.e., sinus issue)?  Yes  No *SRCOLD2W*

d. Date of Birth: 

--	--

 / 

--	--

 / 

--	--	--	--

  
Month Day Year

e. Height: 

--	--	--

 inches

f. Weight: 

--	--	--

 lbs

## 4 POST-TEST:

a. Did any of the following occur during testing? (mark all that apply)  
 Headache *1 SRHACHE*  Dizziness or lightheadedness *1 SRDIZZY*  Coughing *1 SRCOUGH*  
 Shortness of breath *1 SRBREATH*  Other *1 SROTHER*

b. How many manuevers were attempted? 

--

 manuevers *SRMNVRS*



Draft





# ECG

Office Use Only--

MrOS ID#

Acrostic

**ECSTAFF**

ECGStaff ID#

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--	--	--	--

--	--	--	--



① Was an ECG obtained?  Yes

No **ECECG**



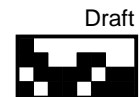
**Why not? ECNOECG**

- 1  Equipment failure
- 2  Participant unable to understand instructions
- 3  Participant unable to physically cooperate
- 4  Participant refused
- 5  Other \_\_\_\_\_

② Was an alert noted?  Yes  No



**Complete the ECG section on the Medical Alert Form**





# Blood Collection & Processing

Office Use Only--														
MrOS ID#					Acrostic					Staff ID#				

1 Was any blood drawn?  Yes  No



2 Was a fasting sample collected?  Yes  No *SCFAST*

3 Time of last meal:  :   am  pm  
Hours Minutes

4 Time of blood draw:  :   am  pm  
Hours Minutes

5 Date of Lab Processing:  /  /   
Month Day Year

Vial #1:(Clear/1.0 mL serum)  Complete  Hemolyzed  Partial  Hemolyzed/partial  Not filled

Vial #2:(Clear/1.0 mL serum)  Complete  Hemolyzed  Partial  Hemolyzed/partial  Not filled

Vial #3:(Clear/1.0 mL serum)  Complete  Hemolyzed  Partial  Hemolyzed/partial  Not filled

Vial #4:(Clear/1.0 mL serum)  Complete  Hemolyzed  Partial  Hemolyzed/partial  Not filled

6 Ending time of laboratory processing:  :   am  pm  
Hours Minutes

7 Enter ID from bar code label:

--	--	--	--	--	--

Affix bar code label:



# Urine Collection & Processing

Office Use Only--

MrOS ID#	Acrostic	Staff ID#
<input type="text"/>	<input type="text"/>	<input type="text"/>

1 Was urine collected?  Yes  No

↓

**A. Date of specimen collection:**  /  /   
Month Day Year

**B. Was a fasting sample collected?**  Yes  No  
*SCUFAST*

**C. Time of last meal:**  :   am  pm

**D. Time participant collected specimen:**  :   am  pm  
Hours Minutes

**E. What void was this?**  
 1st  2nd  >2nd

---

**Date of Lab Processing:**  /  /   
Month Day Year

**Start time of lab processing:**  :   am  pm  
Hours Minutes

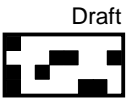
---

Vial #5:(Yellow/4.0mL urine)  Complete  Partial  Not filled

---

Vial #6:(Yellow/4.0mL urine)  Complete  Partial  Not filled

**Enter ID from bar code label:**



Page 22: DXA Form data are not released due to the scan data not being centrally processed for this visit.



# Nottingham Power Rig

Office Use Only-  
MrOS ID#

Acrostic

Staff ID#

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--	--	--	--

NP	STAFF
----	-------

1 Have you had a hip replaced in the last six months?

1  Yes 0  No **NPHIPREP**

Which side have you had replaced? **NPHIPSD**

1  Left (Do not test left side) 2  Right (Do not test right side) 3  Both (Do not test either side)

2 Was the testing done on the RIGHT side?

1  Yes 0  No  
**NPRGTB**

Why not?

- 1  Machine failure
- 2  Refused
- 3  Unable due to physical limitation

**NPRGTBR**

Record seat position used while testing to the nearest centimeter:

NP	SEAT	R			
----	------	---	--	--	--

 cm

Is this distance within 5cm of the seat position from the most recent MrOS visit?

1  Yes 0  No  
**NP5CMDR**

Why not? \_\_\_\_\_

- NP1S2RM
- NPDS2RM
- NP2S2RM
- NP3S2RM
- NP1S2LM
- NPDS2LM
- NP2S2LM
- NP3S2LM
- NP1S2OM
- NPDS2OM
- NP2S2OM
- NP3S2OM

1	<table border="1"><tr><td></td><td></td><td></td></tr></table>				.	<table border="1"><tr><td></td><td></td><td></td></tr></table>				<b>NPRIGHT1</b>	watts
2	<table border="1"><tr><td></td><td></td><td></td></tr></table>				.	<table border="1"><tr><td></td><td></td><td></td></tr></table>				<b>NPRIGHT2</b>	watts
3	<table border="1"><tr><td></td><td></td><td></td></tr></table>				.	<table border="1"><tr><td></td><td></td><td></td></tr></table>				<b>NPRIGHT3</b>	watts
4	<table border="1"><tr><td></td><td></td><td></td></tr></table>				.	<table border="1"><tr><td></td><td></td><td></td></tr></table>				<b>NPRIGHT4</b>	watts
5	<table border="1"><tr><td></td><td></td><td></td></tr></table>				.	<table border="1"><tr><td></td><td></td><td></td></tr></table>				<b>NPRIGHT5</b>	watts

Was the testing done on the LEFT side?

1  Yes 0  No  
**NPLFTB**

Why not?

- 1  Machine failure
- 2  Refused
- 3  Unable due to physical limitation

**NPLFTBR**

Record seat position used while testing to the nearest centimeter.

NP	SEAT	L			
----	------	---	--	--	--

 cm

Is this distance within 5cm of the seat position from the most recent MrOS visit?

1  Yes 0  No  
**NP5CMDL**

Why not? \_\_\_\_\_

- NP1S2RMP
- NP1S2LMP
- NP1S2OMP
- NPDS2RMP
- NPDS2LMP
- NPDS2OMP
- NP2S2RMP
- NP2S2LMP
- NP2S2OMP
- NP3S2RMP
- NP3S2LMP
- NP3S2OMP

1	<table border="1"><tr><td></td><td></td><td></td></tr></table>				.	<table border="1"><tr><td></td><td></td><td></td></tr></table>				<b>NPLEFT1</b>	watts
2	<table border="1"><tr><td></td><td></td><td></td></tr></table>				.	<table border="1"><tr><td></td><td></td><td></td></tr></table>				<b>NPLEFT2</b>	watts
3	<table border="1"><tr><td></td><td></td><td></td></tr></table>				.	<table border="1"><tr><td></td><td></td><td></td></tr></table>				<b>NPLEFT3</b>	watts
4	<table border="1"><tr><td></td><td></td><td></td></tr></table>				.	<table border="1"><tr><td></td><td></td><td></td></tr></table>				<b>NPLEFT4</b>	watts
5	<table border="1"><tr><td></td><td></td><td></td></tr></table>				.	<table border="1"><tr><td></td><td></td><td></td></tr></table>				<b>NPLEFT5</b>	watts

**NPRMAX**  
**NPLMAX**  
**NPOMAX**

**NPABLEB**  
**NPABLEL**  
**NPABLER**  
**NPBTHBR**







# Actigraphy Checklist

Office Use Only--														
MrOS ID#					Acrostic					Staff ID#				

1 Did the participant receive an actigraph?  Yes

No

**VS2ACTIG**  
**VS2ACTRSN**

Watch Serial Number:

What arm was watch worn on?  
(should be non-dominant when possible)

- Left, non-dominant
- Left, dominant
- Right, non-dominant
- Right, dominant

Why not?

- Refused
- Cognitive Impairment
- Physical/Medical Problem
- No watch available/Schedule problem
- Oxygen Use
- Defibrillator
- Other \_\_\_\_\_

2 Date watch given to participant

<input type="text"/>	<input type="text"/>	/	<input type="text"/>	<input type="text"/>	/	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Month			Day			Year			

3 Date watch returned to clinic

<input type="text"/>	<input type="text"/>	/	<input type="text"/>	<input type="text"/>	/	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Month			Day			Year			

4 How many nights were watch data collected?  
(record number of nights in .aw5 file)

nights →

If less than 3 nights, will participant rewear the watch?  Yes  No

5 Was the sleep diary completed?

Yes  No →

Why not?  Refused  
 Unable

Was the diary completed accurately for all days and all sections?  Yes  No

Please indicate which sections were not accurately completed for ALL days (mark all that apply):

- Napping Information
- Removal times information
- Still times information
- Bed time and wake time information

Draft





# PSG Checklist

Office Use Only--									
MrOS ID#					Acrostic			Staff ID#	
								POSTAFF	

1 Did the participant complete the PSG measurement?  Yes  No *POCOMP*

VS2PSG  
VS2PSGRSN

**Why not?**

Refused *POWHYN*  
7

Physical/Medical Problem  
2

No equipment available  
3

Other \_\_\_\_\_  
4

2 Date of overnight PSG:  /  /  *PODATE*  
Month Day Year

3 Safiro ID:  *POPSGID*

4 Please record the following levels from the time of signal verification.

SaO2 level:  % *POBASESAT* Heart rate:  beats per minute *POBASEHRT*

5 Did the participant use oxygen the night of the psg study?  Yes  No *POOXYG*

6 Did the participant use CPAP or BiPAP the night of the psg study?  Yes  No *POCPAP*

7 Did the participant use a mouthpiece (for snoring) the night of the psg study?  Yes  No *POMOUTH*

8 Was the PSG morning survey completed?  Yes  No *POSURV*

**Why not?**

Refused *POSURVN*  
7

Unable  
8