SLEEP HEART HEALTH STUDY

MORNING SURVEY

ID#: PPTID

Field Center: SITE10 ____ ____

Today's date: DATE10 ____ ____ ____
month day year

After you get up, please fill out this form as completely as you can. If you have any questions, the technician will be happy to help you when your monitor is collected.

1 What time did you go to sleep last night?

TSLH10 ____ ____ : TSLM10 ____ ____

TSLA10
- ☐ 1 A.M. *(Midnight is 12:00 A.M.)*
- ☐ 2 P.M.

2 What time did you wake up today?

TWUH10 ____ ____ : TWUM10 ____ ____

TWUA10
- ☐ 1 A.M.
- ☐ 2 P.M.

3 How long did you sleep last night?

HWLGHR10 ____ ____ HOURS HWLGMN10 ____ ____ MINUTES

4 Please rate the quality of your sleep last night by circling a number from 1 to 5 on each of the scales below.

My sleep last night was:

A. Light LTDP10 Deep

1 2 3 4 5

B. Short SHLG10 Long

1 2 3 4 5

C. Restless REST10 Restful

1 2 3 4 5

5 Compared to your usual night's sleep, how well did you sleep last night? *(Check o* HWWELL10

- ☐ 1 Much worse than usual
- ☐ 2 Somewhat worse than usual
- ☐ 3 As well as usual
- ☐ 4 A little better than usual
- ☐ 5 Much better than usual

6 Did you have difficulty falling asleep last night? *(Check one)* DIFFA10

YES	NO
☐ 1	☐ 0

7 How many minutes did it take for you to fall asleep at bedtime last night?

___ ___ ___ MINUTES MINFA10

8 Did you take any medications last night that you didn't tell us about yesterday? MEDS10
(Check one)

- ☐ 1 YES *(Please list them below.)*
- ☐ 0 NO → *Skip to Question 9 on page 3.*
- ☐ 2 UNSURE *(If you are unsure that you told us about a medication, please list it below.)*

Medication Name
Print the first 20 letters only--please print clearly.

Strength (mg)

	Medication Name	Strength (mg)
1		
2		
3		
4		
5		

(Please continue on the back of this survey if you need additional space.)

For Questions 9 - 11, please think back to the four-hour period before you went to sleep last night.

9 How much beer, wine, or liquor (if any) did you have during the 4 hours before you went to sleep last night? *(Please write "0" if you did not drink any of that beverage.)*

WINE10 ___ ___ glasses of wine

SHOTS10 ___ ___ mixed drinks or shots of liquor

BEER10 ___ ___ bottles or cans of beer

10 How many of the following drinks with caffeine (if any) did you have during the 4 hours before you went to sleep last night? *(Please write "0" if you did not drink any of that beverage.)*

COFFEE10 ___ ___ cups of regular coffee (with caffeine)

TEA10 ___ ___ cups of tea with caffeine

SODA10 ___ ___ glasses or cans of cola or other soda with caffeine

11 How much did you smoke (if at all) during the 4 hours before you went to sleep last night?

CGRTTS10 ___ ___ number of cigarettes

PIPE10 ___ ___ number of pipe bowls

CIGARS10 ___ ___ number of cigars

12 How much discomfort, if any, did the following parts of the monitor cause you?

		NONE	VERY LITTLE	MODERATE	A GREAT DEAL
WRHEAD10	The wires on your head	☐ 1	☐ 2	☐ 3	☐ 4
WRFACE10	The wires on your face	☐ 1	☐ 2	☐ 3	☐ 4
PLSTC10	The plastic piece over your lip	☐ 1	☐ 2	☐ 3	☐ 4
BELT10	The belts around your chest and stomach	☐ 1	☐ 2	☐ 3	☐ 4
VEST10	The vest	☐ 1	☐ 2	☐ 3	☐ 4
FINGER10	The finger piece	☐ 1	☐ 2	☐ 3	☐ 4

13 At what time did you finish filling out this survey?

FINH10 ___ ___ : FINM10 ___ ___

FINA10
☐ 1 A.M.
☐ 2 P.M.

Field Center Use Only

☐ 0 Self administered WHOADM10 ☐ Interviewer administered, in:

☐ 1 English ☐ 4 Pima
☐ 2 Spanish ☐ 5 Other, specify:______________________
☐ 3 Lakota ☐ 6 Unknown

Interviewer or Reviewer INTID10 ___ ___ ___ Date: RDATE10 ___ ___ ___
month day year