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

2. What time did you wake up today?
   - TWUH10: TWUM10

3. How long did you sleep last night?
   - HWLGH10 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.

<table>
<thead>
<tr>
<th>My sleep last night was:</th>
<th>A. Light</th>
<th>LTDP10</th>
<th>Deep</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>B. Short</th>
<th>SHLG10</th>
<th>Long</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>C. Restless</th>
<th>REST10</th>
<th>Restful</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>
5 Compared to your usual night’s sleep, how well did you sleep last night? (Check one)  

☐ 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)  

YES ☐ NO ☐  

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

_____ MINFA10 _____ MINUTES  

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

☐ 1 YES (Please list them below.)  
☐ 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.  

1 2 3 4 5  

Strength (mg)  

(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?

WRHEAD10 The wires on your head  
WRFACE10 The wires on your face  
PLSTC10 The plastic piece over your lip  
BELT10 The belts around your chest and stomach  
VEST10 The vest  
FINGER10 The finger piece

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

FINH10: FINM10  FINA10 A.M.  R.M.

Field Center Use Only

0 Self admin  WHOADM10 Interviewer administered, in:

1 English  1 Pima  2 Spanish  
3 Other, specify:______________________________

2 Lakota  6 Unknown

Interviewer or Reviewer INTID10 Date: RDATE10 month day year