I. Data Collection Forms

A) Health Interview Questions

How many cups of coffee or tea, **with caffeine**, do you usually drink in a typical day? (cups_coffee)

How many cans of cola or other soft drinks, **with caffeine**, do you usually drink in a typical day?_____(cans_cola)

The next section asks about specific medical problems. Please indicate if you have been told *by a doctor within the last 5 years* that you have or have had any of these conditions.

Coronary artery disease?____Yes ___No (coronary_ynd)
If yes, indicate how many years ago_____or the year_____you were diagnosed.
(coronary_year)

Atherosclerosis (hardening of the arteries)?____Yes ___No (atheroscl_ynd)
If yes, indicate how many years ago_____or the year_____you were diagnosed.
(atheroscl_year)

Irregular heartbeat or arrhythmia?____Yes ___No (arrhythmia_ynd)
If yes, indicate how many years ago_____or the year_____you were diagnosed.
(arrhythmia_year)

Heart attack or infarct?____Yes ___No (heartattack_ynd)
If yes, indicate how many years ago_____or the year_____you were diagnosed.
(heartattack_year)

Congestive heart failure?____Yes ___No (congestivehf_ynd)
If yes, indicate how many years ago_____or the year_____you were diagnosed.
(congestivehf_year)

Angina?____Yes ___No (angina_ynd)
If yes, indicate how many years ago_____or the year_____you were diagnosed.
(angina_year)

High blood pressure or hypertension?____Yes ___No (hypertension_ynd)
If yes, indicate how many years ago_____or the year_____you were diagnosed.
(hypertension_year)

Stroke?____Yes ___No (stroke_ynd)
If yes, indicate how many years ago_____or the year_____you were diagnosed.
(stroke_year)

Diabetes?____Yes ___No (diabetes_ynd)
If yes, indicate how many years ago_____or the year_____you were diagnosed.
(diabetes_year)

Emphysema or Obstructive Lung Disease?___Yes ___No (emphysema_ynd)
If yes, indicate how many years ago_____or the year_____you were diagnosed.
(emphysema_year)

Thyroid problem?___Yes ___No (thyroid_ynd)
If yes, indicate how many years ago_____or the year_____you were diagnosed.
(thyroid_year)
Asthma?___Yes ___No (asthma_ynd)
If yes, indicate how many years ago_____or the year_____you were diagnosed.
(asthma_year)
Arthritis?___Yes ___No (arthritis_ynd)
If yes, indicate how many years ago_____or the year_____you were diagnosed.
(arthritis_year)
Have you had any of the following procedures?

a. Pacemaker Yes No (pacemaker_ynd)
b. Coronary Artery Stent Yes No (coronary_artery_stent_ynd)
c. Angioplasty Yes No (angioplasty_ynd)
d. Coronary Bypass Yes No (coronarybypass_ynd)
e. Other, Please Explain_____
(other_heart_surgery, other_heart_surgery2)

Please estimate your **usual** consumption of alcoholic beverages:

a. How many cans or bottles of beer might you have per week?_____(beer_week)

b. How many glasses of wine might you have per week? (wine_week)

c. How many mixed drinks or shots might you have per week? (hard_week)

d. If you do not drink alcoholic beverages at all check here____(nondrinker)

Have you ever smoked tobacco regularly?____Yes ___No (smoke)

Do you currently smoke?____Yes ___No (smoke_curr) **If no**, when did you quit?
_____Year (smoke_quit)

How much do you smoke now, **OR** if you quit smoking, how much did you smoke in the past (*answer all that apply*)?

_____Cigarettes per day **OR**_____packs per week; (packs_week)
_____Bowls of pipe tobacco per day; and (bowls_day)
_____Cigars per day. (cigars_day)

Overall, how many years total, have you been **OR** were you a regular smoker?
_____Year (smoke_years)

Many people have periods of low energy or fatigue, but, **during a typical day** do you experience excessive sleepiness when it is difficult to fight an **uncontrollable urge to fall asleep**?____Yes ___No (sleepiness)

The following questions concern your sleep habits.

According to what other have told you or to your own awareness, how often do you snore? (snore_freq)

_1 Never or rarely - only once or a few times ever.
_2 Sometimes - a few nights per month; under special circumstances.
_3 At least once a week, but pattern may be irregular.
_4 Several (3 to 5) nights per week.
_5 Every night or almost every night.
_9 Do not know.

How loud do you think, or have others said, your snoring is? (snore_vol)

_1 Only slightly louder than heavy breathing.
_2 About as loud as mumbling or talking.
_3 Louder than talking.
_4 Extremely loud, can be heard through a closed door.
_9 Do not know.
_8 Does not apply.

According to what others have told you, how often, if ever, do you gasp, choke, or make snorting sounds during sleep?
(choke_freq)

__1_Never or rarely - only once or a few times ever.
__2_Sometimes - a few nights per month; under special circumstances.
__3_At least once a week, but pattern may be irregular.
__4_Several (3 to 7) nights per week.
__9_Do not know.

How often, if ever, have you awakened suddenly with the feeling of gasping or choking? (awake_freq)

__1_Never or rarely - only once or a few times ever.
__2_Sometimes - a few nights per month; under special circumstances.
__3_At least once a week, but pattern may be irregular.
__4_Several (3 to 7) nights per week.
__9_Do not know.

According to what others have told you, or to your own awareness, how often, if ever, do you have momentary periods during sleep when you stop breathing or you breathe abnormally? (apnea_freq)

__1_Never or rarely - only once or a few times ever.
__2_Sometimes - a few nights per month; under special circumstances.
__3_At least once a week, but pattern may be irregular.
__4_Several (3 to 7) nights per week.
__9_Do not know.

How many hours of sleep do you usually get during:

a. a workday night?_____#hours (workday)
b. a weekend or nonwork night?_____#hours (weekend)
c. a typical week from daytime or evening **naps**?_____#hours (*Enter 0 if none*) (naps)

About how many minutes does it **usually** take you to fall asleep at night?_____#minutes (tso)

How often, if ever, do you have any of the following problems sleeping? (*Circle <u>one</u> response for each item*.)

0=Never
1=Rarely (once a month)
2=Sometimes (2-4 times a month)
3=Often (5-15 times a month)
4=Almost always (16-30 times a month)

a. Do you have difficulty getting to sleep? (ps_diff) 01234

b. Do you wake up during the night and have a hard time getting back to sleep? (ps_backsleep) 01234

c. Do you wake up repeatedly during the night? ps_wakerepeat) 01234

d. Do you wake up too early in the morning and can't get back to sleep? (ps_tooearly)	0	1	2	3	4
e. Do you not feel rested during the day no matter how many hours of sleep you had? (ps_notrested)	0	1	2	3	4
f. Do you find it very difficult to wake up in the morning? (ps_wakeup)	0	1	2	3	4
g. Do you have nightmares or disturbing dreams? (ps_nightmare)	0	1	2	3	4
h. Do you have feeling of excessive daytime sleepiness? (ps_eds)	0	1	2	3	4

Are you satisfied with your **usual** night's sleep (*check one*)? (eval_general)

__1__Most of the time _3_Not usually
__2__Some of the time _4_Never

How satisfied are you with the way you are spending your life (*check one*)? (eval_life)

__1_Completely satisfied
__2_Mostly satisfied
__3_Moderately satisfied
__4___Not very satisfied

In general, would you say your health is (*check one*): (eval_health)

__1_Excellent
__2_Very good
__3_Good
__4_Fair
__5_Poor

For your job, do you work (check one): (type_shift)

__1__Daytime hours _2___Night shift_____3__Rotating shift _8_Does not apply

Have you had any nasal congestion or stuffiness **today or tonight** (check all that apply)?

__Y,N_Today (nasal_cong_today)
__ Y,N_Tonight (nasal_cong_tonight)
__ Y,N_None (nasal_cong_none)

Have you had surgery that caused your menstrual periods to stop permanently?
_____Yes _____No (reproductive_surg)

If yes, please provide the following information:

a. Indicate the date of surgery:_____Month/Year
(reproductive_surg_date)

b. Identify the kind of surgery (check one): (reproductive_surg_type)
___1 Hysterectomy, uterus and both ovaries removed.
___2 Hysterectomy, uterus and only one ovary removed.
___3 Hysterectomy, uterus removed, no ovaries removed.
___4 One ovary removed, uterus and one ovary remain.
___5 Both ovaries removed, uterus remains.
___6__ Unsure: _____

Please indicate which category listed below best describes your menstrual cycle (check one).

a. _____ I have fairly regular menstrual periods. Enter the nset and ending date of your most recent cycle:____Month/Day/Year Onset____Month/Day/Year End.

b. _____ My menstrual periods are irregular. Enter the onset and ending date of your most recent cycle:
__Month/Day/Year Onset
__Month/Day/Year End.

c. _____ I have no periods at all/menopause. Enter the date of your very last period or indicate how old you were when you had your last period:
__Month/Year OR
__Age.

(menopausal_status) 0: Regular periods (a), 1: Irregular periods (b), 2: Periods stopped due to menopause ((c) & reproductive_surg=N), 4: Surgery ((c) and reproductive_surg=Y)

(time_since_last_period) = difference between reported last menstrual period and sleep study date in years

Have you ever taken supplemental hormones for menopause? -----Yes -----No
Are you currently taking them?_____Yes _____No

(hormone_suppl) C: Current Use, P: Past use, N=Never use

At first visit: How many children do you have? _____
At follow up visits: Have you had any pregnancies since your last sleep study?_____Yes_____No
If yes, please indicate how many_____
(numpreg)

Have you ever been **told by a doctor** that you have **sleep apnea**?____Yes ___No
(apnea)

If yes, when was this? Month/Year
(apnea_date)

___

Were you told you needed treatment? Yes _____No apnea_need)

If yes, what treatment was recommended?
(apnea_treatment1, apnea_treatment2, apnea_treatment3)
Did you have the treatment?_____Yes ___No (apnea_treated)

Did the treatment help (*check one*)? (treatment_help)

1 Not at all
2 Helped a little
3 Helped moderately
4 Helped a lot

If you are using the recommended CPAP/BiPAP, please indicate:

a. How many nights per week do you use it?_(comp_nights_wk)
b How many hours per night do you use it?_(comp_hrnights)

Commonly Used Summary VariablesTO BE ADDED