

Sleep Habits and Problems

This next section asks questions about your sleep habits and sleep-related problems.

1. On a typical weekday, over the past month, how many hours and minutes do you think you actually slept? *This may be different than the time spent in bed. (Do not include time spent napping.)*

For example:

hours and minutes

Fill in your answer below.

hours and minutes Don't know

SLP010_H FMT_NUMERIC. SLP010_M FMT_NUMERIC.

2. On a typical weekend day, over the past month, how many hours and minutes do you think you actually slept? *This may be different than the time spent in bed. (Do not include time spent napping.)*

hours and minutes Don't know

SLP020_H FMT_NUMERIC. SLP020_M FMT_NUMERIC.

3. In a typical week over the past month, how many days out of 7 did you usually have a daytime or evening nap?

- Less than 1 day per week in the last month SLP040 FMT_SLP040_
 1 day per week
 2 days per week
 3 days per week
 4 days per week
 5 days per week
 6 days per week
 7 days per week
 Don't know



4. **Over the past month, how would you rate your sleep quality overall?**

- Excellent SLP060 FMT_QD4_.
- Very good
- Good
- Fair
- Poor

5. **In the past 12 months, how often did you snore while you were sleeping?**

- Never SLP070 FMT_SNORE_SNORT.
- Rarely (1-2 nights per week)
- Occasionally (3-4 nights per week)
- Frequently (5 or more nights per week)
- Don't know (no one told you that you snore)

6. **In the past 12 months, how often did you snort, gasp, or stop breathing while you were asleep?**

- Never SLP080 FMT_SNORE_SNORT.
- Rarely (1-2 nights per week)
- Occasionally (3-4 nights per week)
- Frequently (5 or more nights per week)
- Don't know (no one told you that you snort, gasp, or stop breathing while sleeping)

7a. **Have you ever been told by a doctor or other health professional that you have sleep apnea?**

- Yes SLP090 FMT_YES_NO.
- No → Go to question 8, page 5
- Don't know → Go to question 8, page 5

7b. **If yes, which treatments for sleep apnea have you had? *Please fill in all that apply.***

- None SLP100_A FMT_YES_NO.
- Weight loss SLP100_B FMT_YES_NO.
- CPAP/BiPAP SLP100_C FMT_YES_NO.
- Surgery SLP100_D FMT_YES_NO.
- Dental device SLP100_E FMT_YES_NO.
- Other SLP100_F FMT_YES_NO.
- Don't know SLP100_G FMT_YES_NO.



8. Have you ever been told by a doctor or other health professional that you have a sleep disorder other than sleep apnea? Please fill in all that apply.

- | | | |
|---|----------|-------------|
| <input type="radio"/> Yes, insomnia | SLP110_A | FMT_YES_NO. |
| <input type="radio"/> Yes, restless legs | SLP110_B | FMT_YES_NO. |
| <input type="radio"/> Yes, narcolepsy | SLP110_C | FMT_YES_NO. |
| <input type="radio"/> Yes, other sleep disorder | SLP110_D | FMT_YES_NO. |
| <input type="radio"/> No | SLP110_E | FMT_YES_NO. |
| <input type="radio"/> Don't know | SLP110_F | FMT_YES_NO. |

In the past month...

- | | Never | Rarely
(1 time) | Sometimes
(2-4 times) | Often
(5-15
times) | Almost
always
(16-30
times) | Don't
know |
|--|-----------------------|-----------------------|--------------------------|--------------------------|--------------------------------------|-----------------------|
| 9. How often did you have trouble falling asleep..... | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| | | | SLP120 | FMT_PASTMONTH. | | |
| 10. How often did you wake up during the night and have trouble getting back to sleep..... | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| | | | SLP130 | FMT_PASTMONTH. | | |
| 11. How often did you wake up too early in the morning and have trouble getting back to sleep..... | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| | | | SLP140 | FMT_PASTMONTH. | | |
| 12. How often did you feel excessively sleepy during the day..... | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| | | | SLP150 | FMT_PASTMONTH. | | |



13. 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. If you have not done some of these things recently, try to guess how they would have affected you.

Chance of Dozing or Falling Asleep

	No chance	Slight chance	Some chance	High chance
13a. Sitting and reading.....	○	○	○	○
	SLP200		FMT_QD23_.	
13b. Watching TV.....	○	○	○	○
	SLP210		FMT_QD23_.	
13c. Sitting inactive in a public place (such as a theater or a meeting).....	○	○	○	○
	SLP220		FMT_QD23_.	
13d. As a passenger in a car for an hour without a break.....	○	○	○	○
	SLP230		FMT_QD23_.	
13e. Lying down to rest in the afternoon when circumstances permit.....	○	○	○	○
	SLP240		FMT_QD23_.	
13f. Sitting and talking to someone.....	○	○	○	○
	SLP250		FMT_QD23_.	
13g. Sitting quietly after a lunch without alcohol.....	○	○	○	○
	SLP260		FMT_QD23_.	
13h. In a car, while stopped for a few minutes in traffic.....	○	○	○	○
	SLP265		FMT_QD23_.	

