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HCHS/SOL Sleep Questionnaire

ID NUMBER:

FORM CODE: SLE
VERSION: A 06/29/07

Contact Occasion SEQ #

Acrostic: _____

ADMINISTRATIVE INFORMATION

0a. Completion Date: / /
Month Day Year

0b. Staff ID:

Instructions: Mark a check in the appropriate box for the response. Unless instructed, mark **ONLY** one response.

The following two questions refer to the times you get in and out of bed in order to sleep (not including naps).

1. What time do you usually go to bed?

a. On weekdays or work or school days? :
am/pm

b. On weekends, or days off? :
am/pm

2. What time do you usually wake up?

a. On weekdays or work or school days? :
am/pm

b. On weekends, or days off? :
am/pm

3. During a usual week, how many times do you nap for 5 minutes or more?

None 0
1 or more times 1

The next questions ask about your sleep habits. Please choose *one* of the answers for each of the following questions. Pick the answer that best describes how often you experienced the situation in the *past 4 weeks*.

- | | No, not
in the past
4 weeks | Yes, less
than once
a week | Yes, 1
or 2 times
a week | Yes, 3
or 4
a week | Yes, 5 or
more times
a week |
|---|-----------------------------------|----------------------------------|--------------------------------|----------------------------|-----------------------------------|
| 4. Did you have trouble falling asleep? | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/> |
| 5. Did you wake up several times at night? | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/> |
| 6. Did you wake up earlier than you planned to? | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/> |
| 7. Did you have trouble getting back to sleep
after you woke up too early? | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/> |
| 8. Did you take sleeping pills to help you sleep? | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/> |
| 9. Did you have sleep difficulties that made
you very irritable? | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/> |
| 10. Did you feel overly sleepy during the day? | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/> |
| 11. Overall, was your typical night's sleep during the past 4 weeks: | | | | | |
| | Very sound or restful | 0 | <input type="checkbox"/> | | |
| | Sound or restful | 1 | <input type="checkbox"/> | | |
| | Average quality | 2 | <input type="checkbox"/> | | |
| | Restless | 3 | <input type="checkbox"/> | | |
| | Very restless | 4 | <input type="checkbox"/> | | |

12. What is the chance that you would doze off or fall asleep (not just "feel tired") in each of the following situations? If you are never or rarely in the situation, please give your best guess for what would happen. (Choose one box for each item)

	No Chance	Slight Chance	Moderate Chance	High Chance
a. Sitting and reading	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
b. Watching TV	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
c. Sitting inactive in a public place (such as a theater or a meeting)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
d. Riding as a passenger in a car for an hour without a break	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
e. Lying down to rest in the afternoon when circumstances permit	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
f. Sitting and talking to someone	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
g. Sitting quietly after a lunch without alcohol	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
h. In a car, while stopped for a few minutes in traffic	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
i. At the dinner table	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
j. While driving	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>

13. How often do you snore now? (Mark only one)

- Never 1
- Rarely (1-2 nights a week) 2
- Sometimes (3-5 nights a week) 3
- Always or almost always (6-7 nights a week) 4
- Don't know 9

14. How often do you have times when you stop breathing during your sleep?

- Never 1
- Rarely (1-2 nights a week) 2
- Sometimes (3-5 nights a week) 3
- Always or almost always (6-7 nights a week) 4
- Don't know 9

15. Do you ever experience a desire to move your legs because of discomfort or disagreeable sensations in your legs?

- No 0 → **END QUESTIONNAIRE**
- Yes 1
- Don't know 9 → **END QUESTIONNAIRE**

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16. 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?

- No 0
- Yes 1
- Don't know 9

17. Are these symptoms worse when you are at rest, with at least temporary relief by activity?

- No 0
- Yes 1
- Don't know 9

18. Are these symptoms worse later in the day or at night?

- No 0
- Yes 1
- Don't know 9