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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"/> | | | |

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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