OMB Control No. 2127-XXXX

Expiration Date XX/XX/XXXX

Study: DRIIVE
Participant:______
Visit: _____
Date__________

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Sleep and Food Intake Survey

As part of this study, it is useful to collect information about your sleep and food, alcohol, and caffeine intake. Please read each question carefully. If something is unclear, ask the researcher for assistance. Your participation is voluntary and you have the right to omit questions if you choose.

1) On a typical ______________, when do you normally go to bed? ______AM/ PM

2) On a typical ______________, when do you normally wake up? ______AM/ PM

3) What time did you go to sleep last night? ____________ AM/PM

4) What time did you wake today? ____________ AM/PM

5) In total, how many hours did you sleep last night? _______

6) Do you feel that you got enough sleep? ❒No ❒Yes

7) Did you take a nap today?
   - ❒ No
   - ❒ Yes, times? _______________________

8) When did you eat your last meal? ______________AM/PM
   a) What did you eat at that meal?

   ____

   ____

9) Have you had anything to eat since your last meal?
   - ❒ No

❒ Yes, when? ______________AM/PM

a)What did you eat? ____

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10)Have you had any nicotine in the last 24 hours?

❒ No
❒ Yes, when? _______________ AM/PM
a) How many cigarettes did you smoke? ____________________________
b)How much chewing tobacco did you use? _________________________
c)Other forms of nicotine? (type and frequency) ______________________

11) Have you had any caffeine in the last 24 hours?

❒ No
❒ Yes, when? _______________ AM/PM
a)How many cups of coffee did you drink? ___________________________
b)How many cans of caffeinated soda did you drink? _________________
c)Other forms of caffeine? (type and frequency) ______________________

12) Have you had any alcohol in the last 24 hours?

❒ No
❒ Yes, when? _______________ AM/PM
a)How many cans of beer did you drink?______________________________
b)How many glasses of wine did you drink? ___________________________
c)How many mixed drinks did you consume? _________________________
d)How many shots of alcohol did you consume? _______________________

13) Have you taken any prescription or over-the-counter medications in the past 24 hours?

❒ No
❒ Yes, Explain what was taken, how much was taken and when it was taken.

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