Attachment 3

Sleep and Food Intake Survey

OMB Control Number: 0925-XXXX Expiration Date: XX/XX/XXXX

Study: MSD
Participant: _____
Visit: _____
Date: _____

Sleep and Food Intake Survey

As part of this study, it is useful to collect information about your sleep and food intake over the last 24 hours. 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)What time did you go to sleep last night? _____ AM/PM

2)What time did you wake today? _____ AM/PM

3)In total, how many hours did you sleep last night? _____

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

5)Did you take a nap today?

❒ No

❒ Yes, times? _____

6)When did you eat your last meal? _____AM/PM

a)What did you eat at that meal?

_____

_____

7)Have you had anything to eat since your last meal?

❒ No

❒ Yes, when? _____AM/PM

a)What did you eat? _____

8)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) _____

9) 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) _____

10) 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? _____