

Attachment 3

Sleep and Food Intake Survey

OMB Control Number: 0925-XXXX

Expiration Date: XX/XX/XXXX

Public reporting burden for this collection of information is estimated to average 3 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: NIH, Project Clearance Branch, 6705 Rockledge Drive, MSC 7974, Bethesda, MD 20892-7974, ATTN: PRA (0925-xxxx). Do not return the completed form to this address.

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? _____