

Study name

Subject number

Date (mm/dd/yyyy)

Time (24 hour clock)

Experimenter initials

NEXT

OMB Control #: 0925-xxxx Expiration Date: mm/dd/yyyy

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[BACK](#)

[NEXT](#)

NADS Driving Survey

As part of this study, it is useful to collect information describing each participant. The following questions ask about you and your health, your driving patterns, and your alcohol consumption. Please read each question carefully. If something is unclear, ask the researcher for help. Your participation is voluntary and you have the right to omit questions if you choose. Please remember that all of your answers will be kept private to the extent permitted by law.

BACK

NEXT

Background Information

What is your date of birth? (Enter in the form mm/dd/yyyy)

What age are you today?

What is your gender?

- ☐ Male
- ☐ Female

What is your marital status?

- ☐ Single, never married
- ☐ Married
- ☐ Domestic Partnership
- ☐ Separated or Divorced
- ☐ Widowed

What was your total household income last year?

- ☐ \$0 - \$24,999
- ☐ \$25,000 - \$29,999
- ☐ \$30,000 - \$34,999
- ☐ \$35,000 - \$39,999
- ☐ \$40,000 - \$49,999
- ☐ \$50,000 - \$59,999
- ☐ \$60,000 - \$69,999
- ☐ \$70,000 - \$79,999
- ☐ \$80,000 - \$89,999
- ☐ \$90,000 - \$99,999
- ☐ \$100,000 or more

☐ \$ 100,000 or more

What is your present employment status?

- ☐ Unemployed
- ☐ Retired
- ☐ Work part-time
- ☐ Work full-time
- ☐ None of the above

Are you Hispanic or Latino?

- ☐ Yes, Hispanic or Latino
- ☐ No, not Hispanic or Latino

What is your race? Please check all that apply.

- ☐ American Indian/Alaska Native
- ☐ Asian
- ☐ Black/African American
- ☐ Native Hawaiian/Other Pacific Islander
- ☐ White

What is the highest level of education that you have completed?

- ☐ Primary School
- ☐ High School Diploma or equivalent
- ☐ Technical School or equivalent
- ☐ Some College or University
- ☐ Associate's Degree
- ☐ Bachelor's Degree
- ☐ Some Graduate or Professional School
- ☐ Graduate or Professional Degree

BACK

NEXT

Driving Experience

How old were you when you started to drive, even if you were not yet licensed?

For which of the following do you currently hold a valid driver's license within the United States?
(Check all that apply)

	Do you possess this type of license?		Year When FIRST Licensed (May be Approximate) (Please enter in format yyyy)
	Yes	No	
Passenger Vehicle License	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Commercial Truck License	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Motorcycle License	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Other: <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Other: <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>

How often do you drive? (Check the most appropriate category)

- ☐ Less than once weekly
- ☐ At least once weekly
- ☐ At least once daily

Approximately how many miles per year do you drive?

How frequently do you drive in the following environments?

	Never	Yearly	Monthly	Weekly	Daily
Residential	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Business District	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Rural Highway (e.g., Route 6)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Interstate (e.g., Interstate 80)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>



How comfortable do you feel when you drive in the following conditions or perform the following maneuvers? (Check the most appropriate answer for each condition)

	Very Uncomfortable	Slightly Uncomfortable	Slightly Comfortable	Very Comfortable	Not Applicable
Highway/freeway	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
After drinking alcohol	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
With children	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
High-density traffic	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Passing other cars	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Changing lanes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Making left turns at uncontrolled intersections	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

[BACK](#)[NEXT](#)

Health Status

How often do you experience motion sickness?

Never -0 1 2 3 4 5 6 7 8 9 Always - 10

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

How severe are your symptoms when you experience motion sickness?

None -0 1 2 3 4 5 6 7 8 9 Severe - 10

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

Have you taken any medication in the past 48 hours?

☐ Yes

☒ No

BACK

NEXT

What is your normal bedtime (hour of the day)?

BACK

NEXT

Crashes

In the past five years, have you been involved in a crash while driving a motor vehicle in which there was damage to your vehicle or another vehicle?

☐ Yes

☐ No

BACK

NEXT

How many times have you been the driver of a car involved in a crash?

- ☐ 1
- ☐ 2
- ☐ 3
- ☒ 4 or more

Were any of these crashes the result of any of the following behaviors?

	Yes	No
Nodding off/struggling to keep eyes open	<input type="checkbox"/>	<input type="checkbox"/>
After drinking alcohol	<input type="checkbox"/>	<input type="checkbox"/>
Talking on cell phone	<input type="checkbox"/>	<input type="checkbox"/>
Texting on cell phone	<input type="checkbox"/>	<input type="checkbox"/>
Talking to passenger	<input type="checkbox"/>	<input type="checkbox"/>
Eating or drinking	<input type="checkbox"/>	<input type="checkbox"/>
Looking at map/GPS	<input type="checkbox"/>	<input type="checkbox"/>
Using handheld device such as iPod	<input type="checkbox"/>	<input type="checkbox"/>
Sending or receiving emails	<input type="checkbox"/>	<input type="checkbox"/>
Reading	<input type="checkbox"/>	<input type="checkbox"/>
Other: <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>

BACK

NEXT

Thank you for completing our questionnaire.

At this time, please notify the experimenter that you have finished.

BACK

NEXT

Experimenter initials

BACK

NEXT

We thank you for your time spent taking this survey.
Your response has been recorded.