**Attachment 1d**

**National Health and Nutrition Examination Survey (NHANES)**

**Ambulatory Blood Pressure Monitoring (ABPM) Feasibility Study**

**Pre ABPM Questionnaires**

Form Approved

OMB No. 0920-0950

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This attachment captures the time needed for participants to have three resting blood pressure measurements, and be fitted with both the ABPM and the Actigraph GT3X-plus Activity Monitor. It also captures the pre ABPM questionnaires which includes sleep quality and demographic questionnaires that participants will fill out (see below).

**Pre ABPM Questionnaires**

DEMOGRAPHIC QUESTIONS FOR 24 HOUR AMBULATORY BLOOD PRESSURE FEASIBILITY STUDY

Are you Hispanic, Latino/a, or Spanish origin (One or more categories may be selected)

a. \_\_\_\_No, not of Hispanic, Latino/a, or Spanish origin

b. \_\_\_\_Yes, Mexican, Mexican American, Chicano/a

c. \_\_\_\_Yes, Puerto Rican

d. \_\_\_\_Yes, Cuban

e. \_\_\_\_Yes, Another Hispanic, Latino/a or Spanish origin

What is your race? (One or more categories may be selected)

a. \_\_\_\_White

b. \_\_\_\_Black or African American

c. \_\_\_\_American Indian or Alaska Native

d. \_\_\_\_Asian Indian

e. \_\_\_\_Chinese

f. \_\_\_\_ Filipino

g. \_\_\_\_Japanese

h. \_\_\_\_Korean

i. \_\_\_\_ Vietnamese

j. \_\_\_\_ Other Asian

k. \_\_\_\_Native Hawaiian

l. \_\_\_\_ Guamanian or Chamorro

m. \_\_\_ Samoan

n. \_\_\_\_Other Pacific Islander

What is the **highest** education completed:

􀁔 less than high school 􀁔 high school graduate or GED 􀁔 more than high school

Are you currently (check 􀀖**only one**):

􀁔 married 􀁔 separated 􀁔 widowed􀁔 single 􀁔 divorced

Do you have a chronic condition(s), or condition(s) you take medications for: YES or NO

If yes, please specify condition(s):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Would you say in general, your health is…

􀁔 excellent 􀁔 very good 􀁔 good 􀁔 fair 􀁔 poor 􀁔 don’t know 􀁔 refused

Do you currently have high blood pressure? YES or NO

Richards-Campbell Sleep Questionnaire (RCSQ)

| **Measure** | **Question**[**a**](http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3667655/table/T1/#TFN1) |
| --- | --- |
| 1. Sleep depth | My sleep last night was: light sleep (0) ... deep sleep (100) |
| 2. Sleep latency | Last night, the first time I got to sleep, I: just never could fall asleep (0) ... fell asleep almost immediately (100) |
| 3. Awakenings | Last night, I was: awake all night long (0) ... awake very little (100) |
| 4. Returning to sleep | Last night, when I woke up or was awakened, I: couldn't get back to sleep (0) ... got back to sleep immediately (100) |
| 5. Sleep quality | I would describe my sleep last night as: a bad night's sleep (0) ... a good night's sleep (100) |
| 6. Noise[b](http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3667655/table/T1/#TFN2) | I would describe the noise level last night as: very noisy (0) ... very quiet (100) |

AM

Subject’s Initials ID# Date Time PM

# PITTSBURGH SLEEP QUALITY INDEX (PSQI)

**INSTRUCTIONS:**

The following questions relate to your usual sleep habits during the past month only. Your answers should indicate the most accurate reply for the majority of days and nights in the past month.

Please answer all questions.

1. During the past month, what time have you usually gone to bed at night?

BED TIME

1. During the past month, how long (in minutes) has it usually taken you to fall asleep each night? NUMBER OF MINUTES
2. During the past month, what time have you usually gotten up in the morning?

GETTING UP TIME

1. During the past month, how many hours of actual sleep did you get at night? (This may be different than the number of hours you spent in bed.)

HOURS OF SLEEP PER NIGHT

***For each of the remaining questions, check the one best response. Please answer all questions.***

1. During the past month, how often have you had trouble sleeping because you . . .
2. Cannot get to sleep within 30 minutes

Not during the Less than Once or twice Three or more

past month

once a week

a week

times a week

1. Wake up in the middle of the night or early morning

Not during the Less than Once or twice Three or more

past month

once a week

a week

times a week

1. Have to get up to use the bathroom

Not during the Less than Once or twice Three or more

past month

once a week

a week

times a week

1. Cannot breathe comfortably

Not during the Less than Once or twice Three or more

past month

once a week

a week

times a week

1. Cough or snore loudly

Not during the Less than Once or twice Three or more

past month

once a week

a week

times a week

1. Feel too cold

Not during the Less than Once or twice Three or more

past month

once a week

a week

times a week

1. Feel too hot

Not during the Less than Once or twice Three or more

past month

once a week

a week

times a week

1. Had bad dreams

Not during the Less than Once or twice Three or more

past month

once a week

a week

times a week

1. Have pain

Not during the Less than Once or twice Three or more

past month

once a week

a week

times a week

1. Other reason(s), please describe

How often during the past month have you had trouble sleeping because of this?

Not during the Less than Once or twice Three or more

past month

once a week

a week

times a week

1. During the past month, how would you rate your sleep quality overall? Very good

Fairly good

Fairly bad

Very bad

1. During the past month, how often have you taken medicine to help you sleep (prescribed or "over the counter")?

Not during the Less than Once or twice Three or more

past month

once a week

a week

times a week

1. During the past month, how often have you had trouble staying awake while driving, eating meals, or engaging in social activity?

Not during the Less than Once or twice Three or more

past month

once a week

a week

times a week

1. During the past month, how much of a problem has it been for you to keep up enough enthusiasm to get things done?

No problem at all

Only a very slight problem

Somewhat of a problem

A very big problem

|  |  |  |
| --- | --- | --- |
| 10. | Do you have a bed partner or room mate?  No bed partner or room mate |  |
|  | Partner/room mate in other room |  |
|  | Partner in same room, but not same bed Partner in same bed |  |

If you have a room mate or bed partner, ask him/her how often in the past month you have had . . .

1. Loud snoring

Not during the Less than Once or twice Three or more

past month

once a week

a week

times a week

1. Long pauses between breaths while asleep

Not during the Less than Once or twice Three or more

past month

once a week

a week

times a week

1. Legs twitching or jerking while you sleep

Not during the Less than Once or twice Three or more

past month

once a week

a week

times a week

1. Episodes of disorientation or confusion during sleep

Not during the Less than Once or twice Three or more

past month

once a week

a week

times a week

1. Other restlessness while you sleep; please describe

Not during the Less than Once or twice Three or more

past month

once a week

a week

times a week

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*Buysse DJ, Reynolds CF, Monk TH, Berman SR, Kupfer DJ: Psychiatry Research, 28:193-213, 1989.*