Attachment 1d

National Health and Nutrition Examination Survey (NHANES)
Ambulatory Blood Pressure Monitoring (ABPM) Feasibility Study
Pre ABPM Questionnaires

Form Approved
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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]
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[a]	I would describe the noise level last night as: very noisy (0) ... very quiet (100)

Subject's Initials_____ID#_____Date_____Time_____AM 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 _____

2. During the past month, how long (in minutes) has it usually taken you to fall asleep each night? NUMBER OF MINUTES _____

3. During the past month, what time have you usually gotten up in the morning?

   GETTING UP TIME _____

4. 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.

5. During the past month, how often have you had trouble sleeping because you . . .

a) Cannot get to sleep within 30 minutes

Not during the past month_____	Less than once a week_____	Once or twice a week_____	Three or more times a week_____

b) Wake up in the middle of the night or early morning

Not during the past month_____	Less than once a week_____	Once or twice a week_____	Three or more times a week_____

c) Have to get up to use the bathroom

Not during the past month_____	Less than once a week_____	Once or twice a week_____	Three or more times a week_____

d) Cannot breathe comfortably

Not during the past month_	Less than once a week_____	Once or twice a week_	Three or more times a week_____
_____		_____	

e) Cough or snore loudly

Not during the past month_	Less than once a week_____	Once or twice a week_	Three or more times a week_____
_____		_____	

f) Feel too cold

Not during the past month_	Less than once a week_____	Once or twice a week_	Three or more times a week_____
_____		_____	

g) Feel too hot

Not during the past month_	Less than once a week_____	Once or twice a week_	Three or more times a week_____
_____		_____	

h) Had bad dreams

Not during the past month_	Less than once a week_____	Once or twice a week_	Three or more times a week_____
_____		_____	

i) Have pain

Not during the past month_	Less than once a week_	Once or twice a week_	Three or more times a week_____
_____	_____	_____	

j) Other reason(s), please describe_____

_____

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

Not during the past month_	Less than once a week_____	Once or twice a week_	Three or more times a week_____
_____		_____	

6. During the past month, how would you rate your sleep quality overall?

Very good _____

Fairly good _____

Fairly bad _____

Very bad _____

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

Not during the past month_	Less than once a week_____	Once or twice a week_	Three or more times a week_____
_____		_____	

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

Not during the past month_	Less than once a week_____	Once or twice a week_	Three or more times a week_____
_____		_____	

9. 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 . . .

a) Loud snoring

Not during the past month_	Less than once a week_____	Once or twice a week_	Three or more times a week_____
_____		_____	

b) 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_____

c) Legs twitching or jerking while you sleep

Not during the past month_ Less than once a week_____ Once or twice a week_ Three or more times a week

d) Episodes of disorientation or confusion during sleep

Not during the past month_____ Less than once a week_____ Once or twice a week_____ Three or more times a week_____

e) Other restlessness while you sleep; please describe_____

Not during the past month_____ Less than once a week_____ Once or twice a week_____ Three or more times a week_____

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