Attachment 1g

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

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Measure	Question ∘
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 ^{ts}	I would describe the noise level last night as: very noisy (0) very quiet (100)

For the following questions, please circle the answer that corresponds to your response on a scale from 0 to 10: 0 = "Not at all" 5 = "Somewhat" 10 = "Extremely"

1. Did you find the device heavy?							1	2	3	4	5	6	7	8	9	10)	
2. Did you find the device comfortable to wear?							1	2	3	4	5	6	7	8	9	10		
3. Did you find the device straightforward to use? 0 1 2 3 4 5 6 7 8 9 10																		
4. Did you find the device cumbersome to wear:																		
0	At home?	0	1	2	3	4		5	6		7	8	}	9		10		
0	At work?	0	1	2	3	4		5	6		7	8	}	9		10	1	
0	Driving?	0	1	2	3	4		5	6 7		7	8		9		10	10	
0	At other times?	0	1	2	3	4		5	6 7		7	8		9		10		
5. Did the noise of the device disturb <u>you</u> :																		
0	At home?	0	1	2	3	4		5	6		7		8	9	9	1	0	
0	At work?	0	1	2	3	4		5	6		7		8		9	1	0	
0	O Driving?		1	2	3	4		5	6		7		8		9	1	.0	
0	At other times?	0	1	2	3	4		5	6	•	7		8		9	1	10	
6. Did the noise of the device disturb <u>others</u> ?																		
0	At home?	0	1	2	_ 3		4		5	6		7		8	(9	10	
0	At work?	0	1	2	3		4		5	6		7		8	(9	10	
0	Driving?	0	1	2	3		4		5	6		7		8		9	10	
0	At other times?	0	1	2	3		4		5	6	•	7		8		9	10	
7. Did you find the device embarrassing to wear? Yes or No																		
8. Did you find the device interfered with your normal sleeping pattern? Yes or No																		
	9. Did you find that wearing the device interfered with your normal activities? O At home? 0 1 2 3 4 5 6 7 8 9 10												10					
0	At home?	0	1	2	3	4		5		6		/	Ö		9		10	

Please circle your response to the next questions.

0

0 1

1

10. If your sleep was disturbed, did the device stop you from falling asleep?

2

2

2

O Yes No Sleep was not disturbed

O At other times? 0 1

11. If your sleep was disturbed, did the device wake you up after you had fallen asleep?

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- O Yes No Sleep was not disturbed
- 12. Did the device disturb you sufficiently to make you remove it during the day?
 - O Yes No Sleep was not disturbed
- 13. Did the device disturb you sufficiently to make you remove it during the night?
 - o Yes No Sleep was not disturbed
- 14. Did you experience pain from wearing the device?
 - o Yes No

O At work?

O Driving?

- 15. Did you experience skin irritation from wearing the device?
 - o Yes No
- 16. Did you experience bruising from wearing the device?
 - o Yes No
- 17. Did the device disturb your partner's sleep?

- o Yes No
- 18. Did you feel annoyed when the machine had to repeat measurements?

 o Yes No