## Attachment 1g

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

Form Approved
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#### Abstract

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## Post ABPM Questionnaires

Richards-Campbell Sleep Questionnaire (RCSQ)

| Measure | Question ${ }^{\text {a }}$ |
| :---: | :---: |
| 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 ${ }^{\text {b }}$ | 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? $\quad 0 \quad 1 x_{2}$
2. Did you find the device comfortable to wear? $\begin{array}{lllllllllllll} & 10 & 1 & 2 & 3 & 4 & 5 & 6 & 7 & 8 & 9 & 10\end{array}$
3. Did you find the device straightforward to use? $0 \begin{array}{llllllllllll} & 1 & 2 & 3 & 4 & 5 & 6 & 7 & 8 & 9 & 10\end{array}$
4. Did you find the device cumbersome to wear:

| o | At home? | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| :--- | :--- | :--- | :--- | :--- | :--- | :--- | :--- | :--- | :--- | :--- | :--- | :--- |
| o | At work? | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| o | Driving? | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| o | At other times? | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

5. Did the noise of the device disturb you:

| o | At home? | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| :--- | :--- | :--- | :--- | :--- | :--- | :--- | :--- | :--- | :--- | :--- | :--- | :--- |
| o | At work? | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| o | Driving? | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| o | At other times? | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

6. Did the noise of the device disturb others?

| o | At home? | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| :--- | :--- | :--- | :--- | :--- | :--- | :--- | :--- | :--- | :--- | :--- | :--- |
| o | At work? | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| o | Driving? | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| o | 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 |
| :--- | :--- | :--- | :--- | :--- | :--- | :--- | :--- | :--- | :--- | :--- | :--- | :--- |
| o | At work? | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| o | Driving? | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| o | At other times? | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

## Please circle your response to the next questions.

10. If your sleep was disturbed, did the device stop you from falling asleep?
o Yes No Sleep was not disturbed
11. If your sleep was disturbed, did the device wake you up after you had fallen asleep?
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
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?

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

