Attachment 1g

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

Form Approved
OMB no. 0920-0950
Expires: 12/31/2017

Assurance of confidentiality – All information which would permit identification of an individual, a practice, or an establishment will be held confidential, will be used for statistical purposes only by NCHS staff, contractors, and agents only when required and with necessary controls, and will not be disclosed or released to other persons without the consent of the individual or establishment in accordance with section 308(d) of the Public Health Service Act (42 USC 242m) and the Confidential Information Protection and Statistical Efficiency Act (PL-107-347).

Post ABPM Questionnaires

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)

EXPERIENCE/ TOLERABILITY QUESTIONNAIRE*

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? 0 1 2 3 4 5 6 7 8 9 10
2. Did you find the device comfortable to wear? 0 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:
   - 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 <u>you</u>:
   - 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 <u>others</u>?
   - 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

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?

- o Yes No

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