

Attachment D12

Pittsburgh Sleep Quality Index

Form Approved
OMB No. 0920-xxxx
Exp. Date xx/xx/20xx

Pittsburgh Sleep Quality Index

III. 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**.

1. During the past month, when have you usually gone to bed?

____: ____ AM
 PM

2. During the past month, how long, in minutes, has it usually taken you to fall asleep?

____ minutes

3. During the past month, when have you usually gotten up?

____: ____ AM
 PM

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

5. For the remaining questions, please check the one best response. Please answer ALL questions.

| During the PAST MONTH , how often have you had trouble sleeping because you . . . | | | | | |
|--|---|---|-------------------------------------|------------------------------------|--|
| | | Not during the past month (1) | Less than once a week (2) | Once or twice a week (3) | Three or more times a week (4) |
| A | Cannot get to sleep within 30 minutes | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| B | Wake up in the middle of the night or early morning | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| C | Have to get up and use the bathroom | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| D | Cannot breathe comfortably | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| E | Cough or snore loudly | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| F | Feel too cold | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| G | Feel too hot | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| H | Have bad dreams | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| I | Have pain | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| J | Other reasons Please describe: _____ _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Public reporting burden of this collection of information is estimated to average 2 minute per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Information Collection Review Office, 1600 Clifton Road NE, MS D-74, Atlanta, Georgia 30333; ATTN: PRA (XXXX).

6. During the past month, how would you rate your sleep quality overall?
- (1) Very good
 - (2) Fairly good
 - (3) Fairly bad
 - (4) Very bad
7. During the past month, how often have you taken medicine (prescribed or “over the counter) to help you sleep?
- (1) Not during the past month
 - (2) Less than once a week
 - (3) Once or twice a week
 - (4) 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?
- (1) Not during the past month
 - (2) Less than once a week
 - (3) Once or twice a week
 - (4) 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?
- (1) No problem at all
 - (2) Only a very slight problem
 - (3) Somewhat of a problem
 - (4) A very big problem
10. Do you have a bed partner or share a room?
- (1) No bed partner or do not share a room
 - (2) Partner/mate in other room
 - (3) Partner in same room, but not in same bed
 - (4) Partner in same bed

