OMB#: 0925-0584
Exp. 2/28/2011

HCHS/SOL Sleep Questionnaire

ID NUMBER:									FORM CODE: SLE VERSION: A 9/10/07	Contact Occasion			SEQ #		

Acrostic: ____________________

ADMINISTRATIVE INFORMATION

0a. Completion Date: ☐☐/☐☐/☐☐☐☐ (Month / Day / Year)   0b. Staff ID: ☐☐☐

Instructions: Enter the answer given by the participant for each response. The special value, "Q", is allowed for cases where the response 'Don't know/refused' is not listed as an option.

The following _two_ *questions refer to the times you get in and out of bed in order to sleep (not including naps).*

1. What time do you usually go to bed?

   a. On weekdays? ☐☐:☐☐ __ __ am/pm

   b. On weekends? ☐☐:☐☐ __ __ am/pm

2. What time do you usually wake up?

   a. On weekdays? ☐☐:☐☐ __ __ am/pm

   b. On weekends? ☐☐:☐☐ __ __ am/pm

3. During a usual week, how many times do you nap for 5 minutes or more?

None	0	☐
1 or 2 times	1	☐
3 or 4 times	2	☐
5 or more times	3	☐

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The next questions ask about your sleep habits. Please choose *one* of the answers for each of the following questions. Pick the answer that best describes how often you experienced the situation in the *past 4 weeks.*

	No, not in the past 4 weeks	Yes, less than once a week	Yes, 1 or 2 times a week	Yes, 3 or 4 a week	Yes, 5 or more times a week
4. Did you have trouble falling asleep?	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
5. Did you wake up several times at night?	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
6. Did you wake up earlier than you planned to?	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
7. Did you have trouble getting back to sleep after you woke up too early?	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
8. Did you take sleeping pills to help you sleep?	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
9. Did you have sleep difficulties that made you very irritable?	1 ☐	2☐	3 ☐	4 ☐	5 ☐
10. Did you feel overly sleepy during the day?	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐

11. Overall, was your typical night's sleep during the past 4 weeks:

Very sound or restful	0 ☐
Sound or restful	1 ☐
Average quality	2 ☐
Restless	3 ☐
Very restless	4 ☐

12. What is the chance that you would doze off or fall asleep (not just "feel tired") in each of the following situations? If you are never or rarely in the situation, please give your best guess for what would happen. (*Choose one box for each item)*

	No Chance	Slight Chance	Moderate Chance	High Chance
a. Sitting and reading	1 ☐	2 ☐	3 ☐	4 ☐
b. Watching TV	1 ☐	2 ☐	3 ☐	4 ☐
c. Sitting inactive in a public place (such as a theater or a meeting)	1 ☐	2 ☐	3 ☐	4 ☐
d. Riding as a passenger in a car for an hour without a break	1 ☐	2 ☐	3 ☐	4 ☐
e. Lying down to rest in the afternoon when circumstances permit	1 ☐	2 ☐	3 ☐	4 ☐
f. Sitting and talking to someone	1 ☐	2 ☐	3 ☐	4 ☐
g. Sitting quietly after a lunch without alcohol	1 ☐	2 ☐	3 ☐	4 ☐
h. In a car, while stopped for a few minutes in traffic	1 ☐	2 ☐	3 ☐	4 ☐
i. At the dinner table	1 ☐	2 ☐	3 ☐	4 ☐
j. While driving	1 ☐	2 ☐	3 ☐	4 ☐

13. How often do you snore now? *(Mark only one)*

Never	1 ☐
Rarely (1-2 nights a week)	2 ☐
Sometimes (3-5 nights a week)	3 ☐
Always or almost always (6-7 nights a week)	4 ☐
Don't know	9 ☐

14. How often do you have times when you stop breathing during your sleep?

Never	1 ☐
Rarely (1-2 nights a week)	2 ☐
Sometimes (3-5 nights a week)	3 ☐
Always or almost always (6-7 nights a week)	4 ☐
Don't know	9 ☐

15. Do you ever experience a desire to move your legs because of discomfort or disagreeable sensations in your legs?

No	0 ☐	→ **END QUESTIONNAIRE**
Yes	1 ☐	
Don't know	9 ☐	→ **END QUESTIONNAIRE**

16. Do you sometimes feel the need to move to relieve the discomfort, for example by walking, or to relieve the discomfort by rubbing your legs?

No	0	☐
Yes	1	☐
Don't know	9	☐

17. Are these symptoms worse when you are at rest, with at least temporary relief by activity?

No	0	☐
Yes	1	☐
Don't know	9	☐

18. Are these symptoms worse later in the day or at night?

No	0	☐
Yes	1	☐
Don't know	9	☐