LTFU
Long-Term Follow-Up Study

SLEEP SURVEY

Please include this sheet when you mail back your questionnaire (an envelope has been provided). For questions about completing either questionnaire, call 1-800-775-2167.

Our mailing address is:

LONG-TERM FOLLOW-UP STUDY
MAYO MAIL CODE 715
420 DELAWARE ST SE
MINNEAPOLIS MN 55455-9940

The following questions relate to your usual sleep habits during the <u>past month</u> only. Your answers should indicate the most accurate reply for the majority of days and nights in the past month. *PLEASE ANSWER ALL THE QUESTIONS.*

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

USUAL BED TIME ☐

circle one: **AM** **PM**

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

NUMBER OF MINUTES ☐

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

USUAL GETTING UP TIME ☐

circle one: **AM** **PM**

4. During the past month, how many hours of actual sleep did you get at night?

HOURS OF SLEEP PER NIGHT ☐

5. During the past month, how often have you had trouble sleeping because you . . .

	Not during the past month	Less than once a week	Once or twice a week	Three or more times a week
a. Cannot get to sleep within 30 minutes---	☐	☐	☐	☐
b. Wake up in the middle of the night or early morning----------	☐	☐	☐	☐
c. Have to get up to use the bathroom------	☐	☐	☐	☐
d. Cannot breathe comfortably----------	☐	☐	☐	☐
e. Cough or snore loudly----------	☐	☐	☐	☐
f. Feel too cold----------	☐	☐	☐	☐
g. Feel too hot----------	☐	☐	☐	☐
h. Had bad dreams----------	☐	☐	☐	☐
i. Have pain----------	☐	☐	☐	☐
j. Other reasons----------	☐	☐	☐	☐

Please describe:

☐

6. During the past month, how would you rate your sleep quality overall?

☐ Very good ☐ Fairly bad

☐ Fairly good ☐ Very bad

7. During the past month . . .

	Not during the past month	Less than once a week	Once or twice a week	Three or more times a week
a. How often have you taken medicine (prescribed or "over the counter") to help you sleep?----------	☐	☐	☐	☐
b. How often have you had trouble staying awake while driving, eating meals, or engaging in social activity?----------	☐	☐	☐	☐

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8. During the past month, how much of a problem has it been for you to keep up enough enthusiasm to get things done?

- ☐ No problem at all
- ☐ Only a very slight problem
- ☐ Somewhat of a problem
- ☐ A very big problem

9. Do you use anything to help you get to sleep (for example, melatonin, yoga, meditation)?---------- **No** ☐ **Yes** ☐

Please specify:

10. Do you use anything to help you stay awake (for example, coffee, other caffeinated drinks, exercise, pills?---------- **No** ☐ **Yes** ☐

Please specify:

11. On a typical day, how much of the following caffeinated beverages do you drink?

- ☐☐ Cups (8 oz) of coffee
- ☐☐ Cans (12 oz) of soda
- ☐☐ Cups of tea
- ☐☐ Bottles (20 oz) of soda

12. Do you have a bed partner or roommate?

- ☐ No bed partner or roommate → *Go to Question 14.*
- ☐ Partner/roommate in other room
- ☐ Partner in same room, but not same bed
- ☐ Partner in same bed

13. If you have a roommate or bed partner, ***ask him or her*** how often in the past month you have had . . .

	Three or more times a week	Once or twice a week	Less than once a week	Not during the past month
a. Loud snoring----------	☐	☐	☐	☐
b. Long pauses between breaths while asleep----------	☐	☐	☐	☐
c. Legs twitching or jerking while you sleep--	☐	☐	☐	☐
d. Episodes of disorientation or confusion during sleep----------	☐	☐	☐	☐
e. Other restlessness while you sleep---------	☐	☐	☐	☐

14. In the last seven days, how often would you describe yourself as . . .

	Very much	Quite a bit	Somewhat	A little bit	Not at all
a. I feel fatigued----------	☐	☐	☐	☐	☐
b. I feel weak all over----------	☐	☐	☐	☐	☐
c. I feel listless ("washed out")----------	☐	☐	☐	☐	☐
d. I feel tired----------	☐	☐	☐	☐	☐
e. I have trouble starting things because I am tired----------	☐	☐	☐	☐	☐
f. I have trouble finishing things because I am tired----------	☐	☐	☐	☐	☐
g. I have energy----------	☐	☐	☐	☐	☐
h. I am able to do my usual activities-----	☐	☐	☐	☐	☐
i. I need to sleep during the day----------	☐	☐	☐	☐	☐
j. I am too tired to eat----------	☐	☐	☐	☐	☐
k. I need help doing my usual activities-	☐	☐	☐	☐	☐
l. I am frustrated by being too tired to do the things I want to do----------	☐	☐	☐	☐	☐
m. I have to limit my social activity because I am tired----------	☐	☐	☐	☐	☐

For the following items, think about your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you.

15. How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired?

	High chance of dozing	Moderate chance of dozing	Slight chance of dozing	Would never doze
a. Sitting and reading----------	☐	☐	☐	☐
b. Watching TV----------	☐	☐	☐	☐
c. Sitting, inactive in a public place, for example, a theater or a meeting----------	☐	☐	☐	☐
d. As a passenger in a car for an hour without a break----------	☐	☐	☐	☐
e. Lying down to rest in the afternoon when circumstances permit----------	☐	☐	☐	☐
f. Sitting and talking to someone----------	☐	☐	☐	☐
g. Sitting quietly after a lunch without alcohol----------	☐	☐	☐	☐
h. In a car, while stopped for a few minutes in traffic----------	☐	☐	☐	☐

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Thank You!

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