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Participant ID: _____

Participant Name Code: _____

Date Form Filled Out:

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(e.g., 10JUN2005)

Interviewer Code: □ □ □

Circle Field Center Location:

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Health Habits Questionnaire (Phase II Follow-Up)

Interviewer Script: The next series of questions will ask you about your usual activity level during your lifetime. If you are not certain, please try to answer the question to the best of your recollection.

Historical Physical Activity Questions:

1. Please choose the category that best describes your usual activity level during a typical week, when you were a teenager?

- 1Moving about only minimally to carry out everyday chores
- 2Light physical activity 1-2 times per week
- 3Light physical activity several times per week
- 4Physical activity causing breathlessness and sweating 1-2 times per week
- 5Physical activity causing breathlessness and sweating several times per week
- 6Physical activity causing breathlessness and heavy sweating several times per week
- 1Refused
- 2Don't Know

2. Please choose the category that best describes your usual activity level during a typical week, when you were around age 25?

- 1Moving about only minimally to carry out everyday chores
- 2Light physical activity 1-2 times per week
- 3Light physical activity several times per week
- 4Physical activity causing breathlessness and sweating 1-2 times per week
- 5Physical activity causing breathlessness and sweating several times per week
- 6Physical activity causing breathlessness and heavy sweating several times per week
- 1Refused
- 2Don't Know

Participant ID: _____

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3. Please choose the category that best describes your usual activity level during a typical week, when you were around age 50?

- 1Moving about only minimally to carry out everyday chores
- 2Light physical activity 1-2 times per week
- 3Light physical activity several times per week
- 4Physical activity causing breathlessness and sweating 1-2 times per week
- 5Physical activity causing breathlessness and sweating several times per week
- 6Physical activity causing breathlessness and heavy sweating several times per week
- 1Refused
- 2Don't Know
- 3Not Applicable

4. Please choose the category that best describes your usual activity level during a typical week, over the past month?

- 1Moving about only minimally to carry out everyday chores
- 2Light physical activity 1-2 times per week
- 3Light physical activity several times per week
- 4Physical activity causing breathlessness and sweating 1-2 times per week
- 5Physical activity causing breathlessness and sweating several times per week
- 6Physical activity causing breathlessness and heavy sweating several times per week
- 1Refused
- 2Don't Know

Sleep Habit Questions

A. Sleep Patterns

Interviewer Script: *The "LONG LIFE Family Study" Investigators are also very interested in examining the relationship between sleep habits and longevity. The following questions will ask specific details about your sleep habits. If you are not certain, please try to answer the question to the best of your ability.*

5. How much sleep do you usually get at night (or in your main sleep period) on weekdays or workdays?

Hours: _____ Minutes: _____ ⁻¹Refused

6. How much sleep do you usually get at night (or in your main sleep period) on weekends or your non-work days?

Hours: _____ Minutes: _____ ⁻¹Refused

7. How many minutes does it usually take you to fall asleep at bedtime?

Minutes: _____ ⁻¹Refused

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

Number of Times: _____ ⁰None ⁻¹Refused

Go to Q12 **Go to Q12**

9. Do you try to "make time" in your schedule for a regular nap or "siesta" in the afternoon? (*Please Check One*)

⁰Never or rarely **Go to Q12**

¹Sometimes

²Often

³Everyday or almost everyday

⁻¹Refused **Go to Q12**

10. When you do nap in the afternoon, how long do you sleep?

Hours: _____ Minutes: _____ ⁻¹Refused

11. What best describes your reason for regular napping in the afternoon? (*Check all that apply*)

¹I do not get enough sleep at night

²I nap due to an illness or for medical reasons

³I nap because it makes me feel refreshed in general

⁴Other Please explain: _____

^RRefused

12. Please indicate how often you experience each of the following. [*Please check one box for each item (a) through (j)*]:

12a. Have trouble falling asleep.

⁰Never

¹Rarely (*1x/month or less*)

²Sometimes (*2-4x/month*)

³Often (*5-15x/month*)

⁴Almost Always (*16-30x/month*)

⁻¹Refused

12b. Wake up during the night and have difficulty getting back to sleep

⁰Never

¹Rarely (*1x/month or less*)

²Sometimes (*2-4x/month*)

³Often (*5-15x/month*)

⁴Almost Always (*16-30x/month*)

⁻¹Refused

12c. Wake up too early in the morning and am unable to get back to sleep

- 0Never
- 1Rarely (*1x/month or less*)
- 2Sometimes (*2-4x/month*)
- 3Often (*5-15x/month*)
- 4Almost Always (*16-30x/month*)
- 1Refused

12d. Feel unrested during the day, no matter how many hours of sleep you had.

- 0Never
- 1Rarely (*1x/month or less*)
- 2Sometimes (*2-4x/month*)
- 3Often (*5-15x/month*)
- 4Almost Always (*16-30x/month*)
- 1Refused

12e. Feel excessively (overly) sleepy during the day.

- 0Never
- 1Rarely (*1x/month or less*)
- 2Sometimes (*2-4x/month*)
- 3Often (*5-15x/month*)
- 4Almost Always (*16-30x/month*)
- 1Refused

12f. Do not get enough sleep.

- 0Never
- 1Rarely (*1x/month or less*)
- 2Sometimes (*2-4x/month*)
- 3Often (*5-15x/month*)
- 4Almost Always (*16-30x/month*)
- 1Refused

12g. Take sleeping pills or other medication to help you sleep.

- 0Never
- 1Rarely (*1x/month or less*)
- 2Sometimes (*2-4x/month*)
- 3Often (*5-15x/month*)
- 4Almost Always (*16-30x/month*)
- 1Refused

12h. Nasal stuffiness, obstruction or discharge at night.

- 0Never
- 1Rarely (1x/month or less)
- 2Sometimes (2-4x/month)
- 3Often (5-15x/month)
- 4Almost Always (16-30x/month)
- 1Refused

12i. Leg jerks.

- 0Never
- 1Rarely (1x/month or less)
- 2Sometimes (2-4x/month)
- 3Often (5-15x/month)
- 4Almost Always (16-30x/month)
- 1Refused

12j. Leg cramps.

- 0Never
- 1Rarely (1x/month or less)
- 2Sometimes (2-4x/month)
- 3Often (5-15x/month)
- 4Almost Always (16-30x/month)
- 1Refused

B. Snoring and Breathing

Interviewer Note: "The next few questions are about snoring and breathing during sleep. To answer these questions, please consider ***both*** what others have told you, as well as what you know to be true and correct."

13. Have you ever snored (now or at any time in the past)?

- 1Yes
- 0No
- 1Refused
- 2Don't Know

Go to Q18

Go to Q18

Go to Q18

14. How often do you snore now? *(Please check one)*

- 0Do not snore any more. **Go to Q17**
- 1Rarely (*less than 1 night/week*)
- 2Sometimes (*1-2 nights/week*)
- 3Frequently (*3-5 nights/week*)
- 4Always or almost always (*6-7 nights/week*)
- 1Refused **Go to Q17**
- 2Don't Know **Go to Q17**

15. How loud is your snoring? *(Please check one)*

- 1Only slightly louder than heavy breathing
- 2About as loud as mumbling or talking
- 3Louder than talking
- 4Extremely loud (can be heard through a closed door)
- 1Refused
- 2Don't Know

16. Has your snoring been _____? *(Please check one)*

- 1Increasing over time?
- 2Decreasing over time?
- 3Staying the same?
- 1Refused
- 2Don't Know

17. Have you ever had somnoplasty, laser treatment, or surgery as treatment for your snoring?

- 1Yes
- 0No
- 1Refused

18. Are there times when you stop breathing during your sleep?

- 1Yes **Go to Q19**
- 0No **Go to Q20**
- 1Refused **Go to Q20**
- 2Don't Know **Go to Q20**

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

- 1Rarely (*less than 1 night/week*)
- 2Sometimes (*1-2 nights/week*)
- 3Frequently (*3-5 nights/week*)
- 4Always or almost always (*6-7 nights/week*)
- 1Refused
- 2Don't Know

20. During the past year, how often have one or more members of your household been in or near the room where you have slept? *Interviewer Note: Living alone should be marked as "never".*

- 1Never
- 2Sometimes
- 3Usually
- 1Refused

21. Have you ever been told by a doctor that you have a sleep disorder (other than sleep apnea)?

- 1Yes
- 0No
- 1Refused

Go to Q23
Go to Q23

22. What sleep disorder were you told that you have? (*Check all that apply*)

- 1Insomnia
- 2Restless Legs
- 3Narcolepsy
- 4Other Please specify: _____
- RRefused

C. Sleepiness

23. What is the chance that you would doze off or fall asleep (not just "feel tired") in each of the following situations? (*Please check one box for each situation. If you are never or rarely in this situation, please give your "best estimate" as to what would happen.*)

23a. Sitting and reading.

- 1No Chance
- 2Slight Chance
- 3Moderate Chance
- 4High Chance
- 1Refused

23b. Watching TV.

- 1No Chance
- 2Slight Chance
- 3Moderate Chance
- 4High Chance
- 1Refused

23c. Sitting inactive in a public place (such as a theater or meeting).

- 1No Chance
- 2Slight Chance
- 3Moderate Chance
- 4High Chance
- 1Refused

23d. Riding as a passenger in a car for an hour without a break.

- 1No Chance
- 2Slight Chance
- 3Moderate Chance
- 4High Chance
- 1Refused

23e. Lying down to rest in the afternoon when circumstances permit.

- 1No Chance
- 2Slight Chance
- 3Moderate Chance
- 4High Chance
- 1Refused

23f. Sitting and talking to someone.

- 1No Chance
- 2Slight Chance
- 3Moderate Chance
- 4High Chance
- 1Refused

23g. Sitting quietly after a meal without alcohol.

- 1No Chance
- 2Slight Chance
- 3Moderate Chance
- 4High Chance
- 1Refused

23h. In a car, while stopped for a few minutes in traffic. *Interviewer Note: Participant should answer as if they were the driver or the passenger.*

- 1No Chance
- 2Slight Chance
- 3Moderate Chance
- 4High Chance
- 1Refused

23i. At the dinner table.

- 1No Chance
- 2Slight Chance
- 3Moderate Chance
- 4High Chance
- 1Refused

23j. While driving.

- 1No Chance
- 2Slight Chance
- 3Moderate Chance
- 4High Chance
- 1Refused