Sueño – Sleep Habits in HCHS

Appendices

Version 5.0
September 28, 2011

Sueño Manual of Procedures Appendices

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<Letterhead>
SUEÑO – Sleep Ancillary to the Hispanic Community Health Study-Study of Latinos

<Date>
<Name>
<Address>

Dear <Name>,

Thank you for your participation in the Hispanic Community Health Study-Study of Latinos (HCHS-SOL). We are now inviting you to participate in a new research study from the HCHS-SOL called SUEÑO – Sleep Ancillary to HCHS-SOL. This study will try to better understand how Hispanic-Americans/Latinos sleep and how this might affect health. It will also help scientists better understand the final results from the Hispanic Community Health Study-Study of Latinos.

Participation in the SUEÑO study is fairly simple. You will be asked to come to the local Field Center at: [SUEÑO Field Center address]. There, you will have your height and weight measured and asked questions about your sleep and things that might affect your sleep. We will then give you a device like a watch to wear on your wrist that will measure when you sleep. You will be asked to wear this device at home for one week.

We will go over these procedures with you again before the study starts. You will receive $100.00 for completing the study.

You were selected from men and women who are participating in the HCHS-SOL who said they would be interested in hearing about future studies. Your name has been used only for the purpose of contacting you and will not be released to anyone. All the information you provide will be kept confidential in accordance with Federal laws. As usual only your Field Center, security-cleared staff at the University of North Carolina Coordinating Center and other staff who may conduct telephone-based interviews or data entry will have access to your personal information. Your personal identity will not be revealed in any publications or results. Your participation is voluntary and will not affect your participation in the HCHS-SOL.

Our clinic staff will telephone you within one week to discuss your interest in participating. We hope you will contribute your time to this important study.

Sincerely,
[Name of local PI]
[Field Center name]
SUEÑO – Sleep Ancillary to the Hispanic Community Health Study – Study of Latinos

<Letterhead>
SUEÑO – Sleep Ancillary to the Hispanic Community Health Study-Study of Latinos

<Date>
<Name>
<Address>

Estimada(o) <Name>,

Gracias por participar en el ESTUDIO SOBRE SALUD DE LA COMUNIDAD HISPANA/ESTUDIO DE LATINOS (conocido como **"**HCHS/SOL**",** por las siglas en inglés de **"**HISPANIC COMMUNITY HEALTH STUDY/STUDY OF LATINOS"). Lo invitamos a participar en un nuevo estudio de investigación llamado SUEÑO- Auxiliares del Sueño a HCHS-SOL. Este estudio tratará de entender mejor cómo los hispanoamericanos /latinos duermen y cómo esto puede afectar la salud. También ayudará a los científicos a comprender mejor los resultados finales del ESTUDIO SOBRE SALUD DE LA COMUNIDAD HISPANA/ESTUDIO DE LATINOS.

Participación en el estudio SUEÑO es bastante simple. Se le pedirá que venga al Centro local en: [SUEÑO Field Center address]. Ahí, se le tomara su estatura y peso y se la harán preguntas sobre su sueño y cosas que pueden afectar su sueño. Después le daremos un aparato parecido a un reloj para usar en su muñeca que medirá cuando duerme. Se le pedirá que use este aparato en su hogar durante una semana.

Repasaremos estos procedimientos con usted otra vez antes que el estudio comience. Recibirá $100.00 por su participación en este estudio.

Usted fue seleccionado entre hombres y mujeres que estaban participando en el estudio HCHS-SOL que expresaron interés en estudios en el futuro. Su nombre ha sido usado con el solo propósito de contactarse con usted y no le será dado a nadie. Toda la información que usted provea será mantenida confidencialmente en conformidad con las leyes Federales. Solamente el personal de su Centro de Investigación, el personal que ha sido verificado por seguridad en el Centro de Coordinación en la Universidad de Carolina del Norte, y el personal encargado de las entrevistas telefónicas o de ingresar datos en el sistema tendrán acceso a su información personal. No se revelará su identidad personal en ninguna publicación ni divulgación de los resultados. Su participación es voluntaria y no afectará su participación en el estudio de HCHS-SOL.

El personal de nuestra clínica lo/la llamará dentro de una semana para preguntarle si le interesa participar. Esperamos que contribuya con su tiempo a este importante estudio.

Sinceramente,
[Name of local PI]
[Field Center name]
SUEÑO – Sleep Ancillary to the Hispanic Community Health Study – Study of Latinos

Sueño – Sleep Habits in HCHS
Recruitment Call Script
9/17/2010

1) **Greeting -** Hello, this is [Caller's Full Name] from the Hispanic Community Health Study. Is Mr./Ms. [Subject's Last Name] available? *(if No, Continue to 1a; if Yes, continue to section 2).*
   a. Is there a better time or a better number to reach Mr./Ms. [Subject's Last Name]? *(Record time and number that subject should be called back; continue to 1b).*
   b. Thank you for your time today. I will try calling Mr./Ms. [Subject's Last Name] at that time/number. Good bye.

2) **Introduction** - Hello Mr./Ms. [Subjects' last Name]. This is [Caller's Full Name] from the Hispanic Community Health Study. I would like to tell you about a new study from the HCHS called Sueño. First, would you rather we speak in English or Spanish? (*Record preferred language on Screening Form. If English continue in English, if Spanish use Spanish script.*)

   Talking about the study should only take 15 minutes; is now a good time to talk? *(If No, continue to section 2a; if Yes, continue to section 2b).*
   a. I understand, is there another time I can call you that would be more convenient? *(Record time that subject should be called back)*. Thank you for your time today. I look forward to talking to you soon. Goodbye.
   b. Great. Did you receive the letter in the mail that we sent you about this new study? *(if No, continue to 2c; if Yes, continue to 2d).*
   c. I am sorry about that, however I can still tell you about the new study over the phone and send you the letter again. What I would like to do today is to 1- tell you about the Sueño study, 2- see if you are interested in being a part of the study and 3 –if you are interested, ask you a few questions to make sure you are eligible for the study (*continue to section 3*).
   d. Good. So today, I would like to 1- tell you a little more about this new study, Sueño, 2- see if you are interested in being a part of the study and 3 –if you are interested, ask you a few questions to make sure you are eligible for the study (*continue to section 3*).

3) **Description of Study** – The Sueño study is studying how Hispanic-Americans/Latinos sleep. In recent years, medical research has found that sleep may be important for health. The Sueño study will try to better understand how Hispanic-Americans/Latinos sleep and how this might affect health. This study will also help scientists better understand the final results from the Hispanic Community Health Study-Study of Latinos.

   Participation in the Sueño study is fairly simple. You will be asked to come to the local Field Center at: [Sueño Field Center address]. There, you will have your weight measured and asked questions about your sleep and things that might affect your sleep. This visit should only take about an hour to complete. We will then give you a device like a watch to wear on your wrist that will measure when you sleep. You will be asked to wear this device at home for one week.

   We will go over these procedures with you again before the study starts. You will receive $100.00 for completing the study.

4) **Subject Questions** – Do you have any questions so far? *(if No, continue to section 5; if Yes, try to answer questions).*

5) **Assess Interest in Participation** – Do you think you would be interested in participating in the Sueño study? *(if No, continue to section 5a; if Yes, continue to section 6).*
   a. That's ok. Thank you for your time today. We appreciate you participation in HCHS. Have a great day. Goodbye.

6) **Assess Eligibility** – Great. We appreciate your interest in participating in the Sueño study. I will ask you a few questions now to make sure you are eligible for participating in the study.
   a. Are you between the ages of 18 and 64? *(If No, go to section 7).*
   b. Has a physician ever diagnosed you with narcolepsy? *(If Yes, go to section 7).*
   c. Has a physician ever prescribed CPAP or BiPAP to treat you for sleep apnea? *(If Yes, go to section 7).*
   d. For women only, are you currently pregnant? *(If Yes, go to section 7).*
   e. *If answer to 6a is Yes and the answers to 6b-6d are No, then subject is eligible, continue to section 8.*

7) **Not Eligible** – Unfortunately, you are not currently eligible to participate in the Sueño study. *(If subject is pregnant (Yes on question 6d), continue to section 7a; if ineligible for another reason continue to section 7d*).
   a. While you are pregnant, you are not eligible to participate. However, you would be eligible 3 month after you give birth. Would it be ok if we contacted you again 3 months after your due date? (*if No, continue to section 7c; if Yes continue to section 7b*).
   b. Thank you. When is your due date? *(record due date).* Great. We will call you again 3 months after then. Thank you for your time today. I look forward to talking to you soon. Goodbye.
   c. That's ok. Thank you for your time today. Goodbye.
   d. Thank you for your time today. We appreciate you participation in HCHS. Have a great day. Goodbye.

8) **Eligible** – Great, you are eligible for the Sueño study. Would you like to schedule your Field Center Visit today? (*if No, continue to 8a; if Yes continue to 8b*)
   a. That's ok. When is the best time to call you again to schedule this visit? (*record time; continue to section 9*).
   b. Good. When would be a convenient time for the visit? (if you know times that are available at your field site you can list them for subject) (*continue to section 10*)

9) **End Call (field center visit not scheduled)** - Again thank you for your time today and for your participation in HCHS. I will call you back to schedule the field center visit. Have a great day. Goodbye.

10) **End Call (field center visit scheduled)** – Again thank you for your time today and for your participation in HCHS. We will send an appointment reminder in the mail and call you again before your field center visit to confirm your appointment. I look forward to talking to you soon. Have a great day. Goodbye.

1. **Greeting**: Hola, le habla [caller's full name] del Estudio de Salud de la Comunidad Hispana. ¿Está el/la Sr/a [Subject's Last name] disponible? (*if No, Continue to 1a; if Yes, continue to section 2).*
   a. ¿Cuál sería un mejor momento para ubicar a el/la Sr/a [Subject's Last name]? (*Record time and number that subject should be called back; continue to 1b).*
   b. *Gracias por su tiempo. Llamaré a el/la Sr/a* [Subject's Last name] a ese número/hora. Adiós.
2. **Introduction**: Hola Sr/a [Subject's Last name]. Le habla [caller's full name] del Estudio de Salud de la Comunidad Hispana. Me gustaría hablarle sobre un nuevo estudio de HCHS llamado Sueño. Primero, ¿prefiere que le hablemos en inglés o español? (*Record preferred language on Screening Form. If English, continue in English, if Spanish use Spanish script).*

   Hablar sobre el estudio toma sólo uno 15 minutos; ¿es éste un buen momento para hablar? (*If No, continue to section 2a; if Yes, continue to section 2b).*
   a. Entiendo, ¿en qué momento puedo yo llamarlo/a que le sea más conveniente? (*Record time that subject should be called back).* Gracias por su tiempo en el día de hoy. Espero hablar con Ud. pronto. Adiós.
   b. Bien. ¿Recibió la carta por correo que le mandamos sobre este nuevo estudio? *(If No, continue to 2c; if Yes, continue to 2d*).
   c. Siento que no la haya recibido, sin embargo puedo aún hablarle sobre el nuevo estudio en el teléfono and mandarle la carta nuevamente. Lo que me gustaría hacer hoy es 1-hablar del estudio Sueño, 2-ver si está interesado/a en formar parte del estudio y 3-si está interesado/a, hacerle unas pocas preguntas para asegurarme que reúna los requisitos necesarios para el estudio (*continue to section 3).*
   d. Perfecto. Lo que me gustaría hacer hoy es 1-hablar del estudio Sueño, 2-ver si está interesado/a en formar parte del estudio y 3-si está interesado/a, hacerle unas pocas preguntas para asegurarme que reúna los requisitos necesarios para el estudio (*continue to section 3).*

3. **Description of Study—**El estudio Sueño está estudiando como los hispanoamericanos/latinos duermen. En los últimos años la investigación médica ha encontrado que el sueño puede ser importante para la salud. El estudio Sueño tratará de entender mejor cómo los hispanoamericanos/latinos duermen y cómo esto puede afectar la salud. Este estudio también ayudará a los científicos a entender mejor los resultados finales del Estudio de Salud de la Comunidad Hispana—Estudio de Latinos.

   La participación en el estudio Sueño es bastante simple. Se le pedirá que venga al centro local en: [Sueño Field Center address]. Allí, se le medirá su peso y se le harán preguntas sobre su sueño y cosas que afecten su sueño. Completar esta visita sólo lleva aproximadamente una hora de su tiempo. Le daremos un aparato como un reloj que se lleva en su muñeca que medirá cuando Ud duerme. Se le pedirá que use este aparato en casa durante una semana.

   Repasaremos estas instrucciones con Ud. antes de empezar el estudio. Recibirá $100 por completar el estudio.

4. **Subject Questions:** ¿Tiene alguna pregunta hasta ahora? (*If No, continue to section 5; If Yes, try to answer questions).*

5. **Assess Interest in Participation**: Cree que está interesado/a en participar en el estudio Sueño? (*If No, continue to section 5ª; if Yes, continue to section 6).*

    a. Está bien. Gracias por su tiempo en el día de hoy. Apreciamos su participación en HCHS. Tenga un buen día. Adiós.

6. **Assess Eligibility:** Bien. Apreciamos su interés en participar en el estudio Sueño. Le voy a hacer algunas preguntas ahora para estar seguro/a que reúne los requisitos necesarios para participar en el estudio.
    a. ¿Tiene entre 18 y 64 años? (*If No, go to section 7).*
    b. ¿Ha sido en algún momento diagnosticado/a con narcolepsia por un médico? *(If Yes, go to section 7).*
    c. ¿Ha sido recetado/a CPAP o BIPAP por un médico para tratarlo/a por apnea del sueño?
    d. *For women only*, ¿está actualmente embarazada? *(If Yes, go to section 7)*
    e. *If answer to 6a is Yes and the answers to 6b-6d are No, then subject is eligible, continue to section 8.*

7. **Not Eligible**- Desafortunadamente, usted actualmente no cumple con los requisitos para participar en el estudio Sueño. (If subject is pregnant (Yes on question 6d), continue to section 7a; if ineligible for another reason continue to section 7d).
    a**.** Mientras esté embarazada usted no cumple con los requisitos necesarios para participar. Sin embargo, usted los cumpliría 3 meses después de dar a luz. ¿Estaría bien si la contactamos nuevamente 3 meses luego de haber dado a luz? (*if No, continue to section 7c; if Yes continue to section 7b)*
    b. Gracias. ¿En qué fecha da a luz? (record due date). Muy Bien. La llamaremos de nuevo 3 meses más tarde. Gracias por su tiempo en el día de hoy. Espero hablar con usted pronto. Adiós.
    c. Eso está bien. Gracias por su tiempo en el día de hoy. Adiós.
    d. Gracias por su tiempo en el día de hoy. Apreciamos su participación en HCHS. Que tenga un buen día. Adiós.

8. **Eligible**- Muy bien, usted es elegible para el estudio Sueño. ¿Le gustaría coordinar una cita para su Centro hoy? (*if No, continue to 8a; if Yes continue to 8b*)
    a. Está bien. ¿Cuándo sería el mejor momento para llamarlo/a nuevamente y coordinar esta cita? (record time; continue to section 9).
    b. Bien. ¿Cuándo sería un tiempo conveniente para su visita? (if you know times that are available at your field site you can list them for subject) (*continue to section 10*)

9. **End Call (field center visit not scheduled)-** Nuevamente gracias por su tiempo en el día de hoy y por su participación en HCHS. Lo/a llamaré de nuevo para coordinar la visita al centro. Que tenga un buen día. Adiós.

10. **End Call (field center visit scheduled)-** Nuevamente gracias por su tiempo en el día de hoy y por su participación en HCHS. Mandaremos un recordatorio de la cita en el correo y lo/a llamaremos de nuevo antes de su visita al centro para conformar su cita. Que tenga un buen día. Adiós.

Screening Form
HCHS/SOL Sleep Ancillary Study

ID NUMBER:									FORM CODE: VERSION: A 09/08/10	Contact Occasion	0	1	SEQ #	0	1

ADMINISTRATIVE INFORMATION

0a. Completion Date (mm/dd/yyyy): ☐☐/☐☐/☐☐☐☐ 0b. Staff ID: ☐☐☐

Instructions: This individual eligibility screening form must be completed before the participant can be scheduled for their ancillary study interview. Enter one form per person screened for the ancillary study.

NOTE TO STAFF: Use appropriate Sueño recruitment script when completing this form.

A. Eligibility Screening Status for Individuals in Sueño Ancillary Study

1. Does the participant prefer Spanish or English?
   - Neither language 0 ☐ → **INELIGIBLE**
   - Spanish 1 ☐
   - English 2 ☐

2. Is the participant between the age of 18 and 64?
   - No 0 ☐ → **INELIGIBLE**
   - Yes 1 ☐

3. Has participant been diagnosed by physician with narcolepsy?
   - No 0 ☐
   - Yes 1 ☐ → **INELIGIBLE**

4. Is participant using CPAP or BiPAP for treatment of sleep apnea?
   - No 0 ☐
   - Yes 1 ☐ → **INELIGIBLE**

5. Is participant currently pregnant?
   - No 0 ☐
   - Yes 1 ☐ → **GO TO QUESTION 5a**

5a. If yes, would participant be willing to participate after delivery?
- No 0 ☐ → **INELIGIBLE**
- Yes 1 ☐ → **DEFERRED, note follow up call date**

5b. If yes, when is estimated due date? (mm/dd/yyyy): ☐☐/☐☐/☐☐☐☐

6. Individual Participation Status:
   - Refuses to participate 1 ☐
   - Unable to contact, status unknown 2 ☐
   - Ineligible 3 ☐ → **INELIGIBLE, closing script**
   - Agrees to participate 4 ☐ → **ELIGIBLE, schedule visit**
   - Deferred 5 ☐

6a. Appointment Date (mm/dd/yyyy): ☐☐/☐☐/☐☐☐☐

6b. Appointment Time: ☐☐:☐☐ _ _ (am/pm)

B. Demographic Information Pre-filled by HCHS/SOL Data Management System

ID NUMBER:								FORM CODE: VERSION: A 09/08/10	Contact Occasion			SEQ #		

7. Gender: Male 1☐ Female 2☐

8. Age: ☐☐ years

9. Hispanic/Latino background from PIE/PIS

Dominican or Dominican Descent	0 ☐
Central American or Central American descent	1 ☐
Cuban or Cuban descent	2 ☐
Mexican or Mexican descent	3 ☐
Puerto - Rican or Puerto Rican descent	4 ☐
South American or South American descent	5 ☐
More than one heritage	6 ☐
Other	7 ☐

If other, please specify: _____

10. Self identification of racial group from PIE/PIS

American Indian or Alaskan Native	1 ☐
Asian	2 ☐
Native Hawaiian or Other Pacific Islander	3 ☐
Black or African – American	4 ☐
White	5 ☐
More than one race	6 ☐
Unknown or Not reported	7 ☐

Sueño – Sleep Habits in HCHS/SOL

Screening Form (ANE) Question by Question Instructions

General Instructions
The screening form (ANE) is completed at the time of screening call of identified HCHS/SOL participants that may be eligible for Sueño. The form will document individual eligibility and enrollment into the ancillary study. It is important to complete a form for each participant who is screened for the ancillary study in order to estimate refusal rates. Unbiased estimates of refusal rates will enable the investigators to manage recruitment more efficiently and to be able to characterize enrollment.

Once part A of each form is complete, it should be keyed immediately into the Sueño study data management system within 48-72 hours after collection. Note that weekly recruitment and scheduling reports that are being shared with the study investigators and project office based on data from these forms. Part B of the form is automatically filled by the HCHS/SOL DMS using information from the main study baseline files.

Question by Question Instructions
PART A

Q1 This question asks the respondent his/her language of preference. If the respondent does not feel comfortable communicating in either Spanish or English, the person is ineligible. Read the closing script and end call with respondent. Continue to Q6 to complete individual participation status.
If a person responds, "It does not matter", probe further to determine his/her language of preference. Mark either Spanish or English. Continue to Q2.

Q2 The question asks if the respondent is within the age limits of the study. If they have not yet had their 18th birthday or have had their 65th birthday, then they are ineligible. Read the closing script, end call with respondent and continue to Q6 to complete individual participation status. If respondent is between 18 and 64 years of age (inclusive), continue to Q3.

Q3 The question asks about diagnosis of narcolepsy. If they were diagnosed by a physician with narcolepsy they are ineligible. Read the closing script, end call with respondent and continue to Q6 to complete individual participation status. If respondent has never been diagnosed with narcolepsy by a physician even if they believe they may have the disease, continue to Q4.

Q4 The question asks about usage of CPAP or BiPAP for the treatment of sleep apnea. If they have used CPAP or BiPAP in their home for sleep apnea they are ineligible. Read the closing script, end call with respondent and continue to Q6 to complete individual participation status. If respondent has never used CPAP or BiPAP or only used it while in the hospital, continue to Q5.

Q5 This question only needs to be asked of female respondents; it asks if the respondent is currently pregnant. For male respondents automatically mark "no" and continue to Q6. If the respondent is currently pregnant, it does not necessarily exclude them. The respondent can be deferred until 3 months after their delivery date. If the respondent is pregnant, continue to Q5a. If the respondent is not pregnant, continue to Q6

Q5a The question assesses whether the respondent would be willing to participate after delivery. If they are not interested in deferring until after delivery, then they are ineligible; read the closing script, end the call and continue to Q6. Please indicate on Q6 that the respondent refuses to participate (not ineligible). If the respondent is interested in deferring, continue to Q5b.

Q5b The question asks the respondent their due date. Record date. This information will be used to determine when the respondent should be re-contacted and screened again for eligibility. Continue to Q6.

Q6 This question is for administrative purposes only. It is a status code for the individual level eligibility.

Refuses to participate – respondent is not interested in ancillary study participation/not interested in deferring if pregnant. Participants who miss multiple appointments should have their status changed to this status.

Unable to contact, eligibility not confirmed – NO contact has been made after the required number of attempts to contact this individual, and his/her individual eligibility status is unknown. The required number of attempts is determined based on local Field Center procedures.

Ineligible – respondent may be ineligible due to one of the following criteria for participation:

(1) Respondent is not between 18 and 64 years of age,
(2) Respondent has diagnosis of narcolepsy
(3) Respondent has used CPAP or BiPAP for the treatment of sleep apnea

Agrees to participate – Respondent agrees to participate. Go to 6a to schedule interview. Remember to change the appointment date/time if the subject reschedules.

Q6a Set appointment date and record with two digit month, two digit day, and four digit year.

Q6b Set appointment time and record with two digit hour and two digit minute. Record "AM/PM" in the spaces provided.

PART B

Q7-Q10 The demographic characteristics for the participants are automatically filled by the HCHS/SOL data management system. Leave blank; there is no need to enter this information for the ancillary study.

Sueño Screening Contact Worksheet

HCHS/SOL PARTICIPANT ID Number: ☐☐☐☐☐☐☐☐

Date of initial screening contact ☐☐/☐☐/☐☐☐☐
MM / DD / YYYY

Day of Week Date (MM/DD/YY)	Time	Notes	Result Code	Interviewer Code
S M T W T F S / /	A P			
S M T W T F S / /	A P			
S M T W T F S / /	A P			
S M T W T F S / /	A P			
S M T W T F S / /	A P			
S M T W T F S / /	A P			
S M T W T F S / /	A P			
S M T W T F S / /	A P			
S M T W T F S / /	A P			
S M T W T F S / /	A P			
S M T W T F S / /	A P			
S M T W T F S / /	A P			
S M T W T F S / /	A P			
S M T W T F S / /	A P			
S M T W T F S / /	A P			
S M T W T F S / /	A P			

***Enter the *final* result of screening attempts on the Ancillary Study Screening form (ANE)**

(**1**) Refuses to participate in ancillary study
(**2**) Unable to contact, status unknown
(**3**) Ineligible for ancillary study
(**4**) Agrees to participate in ancillary study
(**5**) Deferred

Appendix II – Medication Usage.....16

A. Medication Usage Form (MDE/MDS).....17
   a. English Version.....17
   b. Spanish Version.....23
B. Medication Usage QxQ.....29

Public reporting burden for this collection of information is estimated to average 06 minutes 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: NIH, Project Clearance Branch, 6705 Rockledge Drive, MSC 7974, Bethesda, MD 20892-7974, ATTN: PRA (0925-0584). Do not return the completed form to this address.

HCHS/SOL Medication Use Questionnaire

ID NUMBER:									FORM CODE: MDE VERSION: A 8/30/07	Contact Occasion			SEQ #		

Acrostic: _____

ADMINISTRATIVE INFORMATION

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

Instructions: This form should be completed during the participant's visit. Affix the participant ID label above. Whenever numerical responses are required, enter the number so that the last digit appears in the rightmost box. Enter leading zeroes where necessary to fill all boxes. If a number is entered incorrectly, mark through the incorrect entry with an "=". Code the correct entry clearly above the incorrect entry.

A. Reception

As you know, HCHS/SOL is recording all prescription and over-the-counter medications used by participants in the past four weeks, including cold and allergy medications, vitamins, herbal remedies, and other supplements. These medications include solid and non-solid formulations that you may swallow, inhale, apply to the skin or hair, inject, implant, or place in the ears, eyes, nose, mouth, or any other part of the body.

1. Did you bring all the medications that you used in the past four weeks, or their containers?

Yes, all of them 1 ☐ → **GO TO SECTION B, QUESTION 5**
No, some of them 2 ☐ → **GO TO SECTION A, QUESTION 3**
No, none of them 3 ☐

2. Is this because you forgot, because you have not taken any medications at all in the last four weeks, or because you could not bring your medications?

Took no medication 1 ☐ → **GO TO SECTION C, QUESTION 34**
Forgot or was unable to bring medication 2 ☐

That's alright. Since the information on medications is so important, we would still like to ask you about it during the interview.

3. May we follow up on this after the visit so that we can get the information from the other medication labels? *(Explain follow-up options)*

No or not applicable.. 0 ☐ → **Scan/transcribe what you can in Section B and attempt to convert refusals; indicate this on tracking form**
Yes..... 1 ☐

4. Describe method of follow-up to be used:_____

ID NUMBER:									VERSION: A 8/30/07	Occasion			SEQ #		

B. Medication Record

Copy the MEDICATION UPC / NDC from each medication label. For each medication, begin with the left-most space in fields a-c and the rightmost space in field d. Using upper case letters, carefully copy the MEDICATION NAME. Using periods to indicate decimal points, copy the formulation STRENGTH (weight for solids and concentration for non-solids). Using upper case letters and standard abbreviations, copy the UNITS used to measure strength. For combination medications, use a forward slash (/) to separate active ingredients, corresponding strengths, and units.

#	(a) Medication UPC / NDC		Medication name (b)
5.			
	(c) Strength	(d) Units	
6.			
	(c) Strength	(d) Units	
7.			
	(c) Strength	(d) Units	
8.			
	(c) Strength	(d) Units	
9.			
	(c) Strength	(d) Units	
10.			
	(c) Strength	(d) Units	
11.			
	(c) Strength	(d) Units	
12.			
	(c) Strength	(d) Units	
13.			
	(c) Strength	(d) Units	
14.			
	(c) Strength	(d) Units	

ID NUMBER:									VERSION: A 8/30/07	Occasion			SEQ #		

#	(a) Medication UPC		Medication name (b)
15.			
	(c) Strength	(d) Units	
16.			
	(c) Strength	(d) Units	
17.			
	(c) Strength	(d) Units	
18.			
	(c) Strength	(d) Units	
19.			
	(c) Strength	(d) Units	
20.			
	(c) Strength	(d) Units	
21.			
	(c) Strength	(d) Units	
22.			
	(c) Strength	(d) Units	
23.			
	(c) Strength	(d) Units	
24.			
	(c) Strength	(d) Units	
25.			
	(c) Strength	(d) Units	

ID NUMBER:									VERSION: A 8/30/07	Occasion			SEQ #		

#	(a) Medication UPC		Medication name (b)
26.			
	(c) Strength	(d) Units	
27.			
	(c) Strength	(d) Units	
28.			
	(c) Strength	(d) Units	
29.			
	(c) Strength	(d) Units	

30. Total number of medications in bag.....

31. Number of medications in bag unable to successfully scan or transcribe

32. HCHS/SOL ID staff number of person scanning / transcribing medications

a. Scanner / transcriber (items 5-29): .....

b. Date of scanning / transcription: ..... / /
Month Day Year

ID NUMBER:									VERSION: A 8/30/07	Occasion			SEQ #		

C. Medication Use Interview
Now I would like to ask about a few specific medications.

33. Were any of the medications you took during the last four weeks for: *(If "Yes", verify that the medication NAME is on the medication record.)*

	No	Yes	Unknown
a. Asthma	0 ☐	1 ☐	9 ☐
b. Chronic bronchitis or emphysema	0 ☐	1 ☐	9 ☐
c. High blood sugar or diabetes	0 ☐	1 ☐	9 ☐
d. High blood pressure or hypertension	0 ☐	1 ☐	9 ☐
e. High blood cholesterol	0 ☐	1 ☐	9 ☐
f. Chest pain or angina	0 ☐	1 ☐	9 ☐
g. Abnormal heart rhythm	0 ☐	1 ☐	9 ☐
h. Heart failure	0 ☐	1 ☐	9 ☐
i. Blood thinning	0 ☐	1 ☐	9 ☐
j. Stroke	0 ☐	1 ☐	9 ☐
k. Mini-stroke or TIA	0 ☐	1 ☐	9 ☐
l. Leg pain while walking or claudication	0 ☐	1 ☐	9 ☐

34. During the last four weeks, did you take any aspirin or aspirin-containing products including Alka-Seltzer, cold and allergy medication or headache powder? This **excludes** acetaminophen (for example, Tylenol), ibuprofen (for example, Advil, Motrin or Nuprin), and naproxen (for example, Aleve).

Show participant List #1: Commonly Used Aspirin or Aspirin-Containing Products

No 0 ☐ → **GO TO QUESTION 37**
Yes 1 ☐
Unknown 9 ☐ → **GO TO QUESTION 37**

35. How many days during the last four weeks did you take aspirin or aspirin-containing medication?

☐☐ Number of days

If number of days equals "00" → **GO TO QUESTION 37**

36. For what purpose are you taking aspirin? (*Interviewer: Do NOT read choices.)*

Participant mentioned avoiding heart attack or stroke 1 ☐
Participant did not mention avoiding heart attack or stroke 2 ☐

ID NUMBER:									FORM CODE: MDE VERSION: A 8/30/07	Contact Occasion			SEQ #		

37. During the past four weeks, did you take any [other] medication for arthritis, fever, or muscle aches and pains, or cramps? *(Read bracketed "other" unless no medications were reported.)*

No 0 ☐
Yes 1 ☐
Unknown 9 ☐

38. **Excluding** aspirin, acetaminophen (for example, Tylenol), and corticosteroids (for example prednisone), are you NOW taking other anti-inflammatory or arthritis medications on a regular basis? Common examples are shown on this list.

Show participant List #2: Commonly Used Non-Steroidal Anti-Inflammatory Drugs, NSAIDS

No 0 ☐ → **END QUESTIONNAIRE**
Yes 1 ☐
Unknown 9 ☐ → **END QUESTIONNAIRE**

39. Unless already recorded in Items B5-B29, record the following information for the medication identified by Item 38.

Already recorded 1 ☐

(a) Medication UPC		Medication name (b)
☐☐☐☐☐☐☐☐☐☐☐☐		
(c) Strength	(d) Units	

40. How many pills per week are you taking, on average?

☐☐ Number of pills per week

41. Staff ID number of person who interviewed the participant: ..... ☐☐☐

Medication Use Questionnaire_Spanish
HCHS/SOL Sleep Ancillary Study

ID NUMBER:									FORM CODE: MDS VERSION: A 08/18/10	Contact Occasion			SEQ #		

ADMINISTRATIVE INFORMATION

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

Instructions: This form should be completed during the participant's visit. Affix the participant ID label above. Whenever numerical responses are required, enter the number so that the last digit appears in the rightmost box. Enter leading zeroes where necessary to fill all boxes. If a number is entered incorrectly, mark through the incorrect entry with an "=". Code the correct entry clearly above the incorrect entry.

A. Reception

Como usted sabe, HCHS/SOL (por sus siglas en inglés) está llevando un registro de todos los medicamentos que los participantes han usado en las últimas cuatro semanas (ya sea de venta libre o aquellos que se obtienen con receta médica), incluyendo medicamentos para la gripe o alergias, vitaminas, remedios a base de hierbas y otros suplementos. Estos medicamentos incluyen fórmulas sólidas y no sólidas que usted haya ingerido, inhalado, que se haya aplicado en la piel o en el cabello, que se haya inyectado, implantado o colocado en los oídos, ojos, nariz, boca o cualquier otra parte del cuerpo.

1. ¿Trajo usted todos los medicamentos que ha usado en las últimas cuatro semanas o trajo sus envases?

   Sí, todos 1 ☐ → **GO TO SECTION B, QUESTION 5**
   No, algunos de ellos 2 ☐ → **GO TO SECTION A, QUESTION 3**
   No, ninguno de ellos 3 ☐

2. ¿Se debe esto a que se le olvidó o porque no ha estado tomando ningún medicamento en las últimas cuatro semanas, o porque no pudo traer sus medicamentos?

   No tomó ningún medicamento 1 ☐ → **GO TO SECTION C, QUESTION 34**
   Se le olvidó o no pudo traer los medicamentos 2 ☐

Está bien. En vista de que la información sobre los medicamentos es muy importante, todavía nos gustaría preguntarle sobre ellos durante la entrevista.

3. ¿Podemos hacer un seguimiento de esto después de la visita, para que así podamos obtener la información sobre las etiquetas de los otros medicamentos? *(Explain follow-up options)*

   No or not applicable.. 0 ☐ → **Scan/transcribe what you can in Section B and attempt to convert refusals; indicate this on tracking form**
   Yes..... 1 ☐

4. Describe method of follow-up to be used:_____

ID NUMBER:									VERSION: A 08/18/10	Occasion			SEQ #		

B. Medication Record

Copy the MEDICATION UPC / NDC from each medication label. For each medication, begin with the left-most space in fields a-c and the rightmost space in field d. Using upper case letters, carefully copy the MEDICATION NAME. Using periods to indicate decimal points, copy the formulation STRENGTH (weight for solids and concentration for non-solids). Using upper case letters and standard abbreviations, copy the UNITS used to measure strength. For combination medications, use a forward slash (/) to separate active ingredients, corresponding strengths, and units.

#	(a) Medication UPC / NDC		Medication name (b)
5.			
	(c) Strength	(d) Units	
6.			
	(c) Strength	(d) Units	
7.			
	(c) Strength	(d) Units	
8.			
	(c) Strength	(d) Units	
9.			
	(c) Strength	(d) Units	
10.			
	(c) Strength	(d) Units	
11.			
	(c) Strength	(d) Units	
12.			
	(c) Strength	(d) Units	
13.			
	(c) Strength	(d) Units	
14.			
	(c) Strength	(d) Units	

ID NUMBER:									VERSION: A 08/18/10	Occasion			SEQ #		

#	(a) Medication UPC		Medication name (b)
15.			
	(c) Strength	(d) Units	
16.			
	(c) Strength	(d) Units	
17.			
	(c) Strength	(d) Units	
18.			
	(c) Strength	(d) Units	
19.			
	(c) Strength	(d) Units	
20.			
	(c) Strength	(d) Units	
21.			
	(c) Strength	(d) Units	
22.			
	(c) Strength	(d) Units	
23.			
	(c) Strength	(d) Units	
24.			
	(c) Strength	(d) Units	
25.			
	(c) Strength	(d) Units	

ID NUMBER:									VERSION: A 08/18/10	Occasion			SEQ #		

#	(a) Medication UPC		Medication name (b)
26.			
	(c) Strength	(d) Units	
27.			
	(c) Strength	(d) Units	
28.			
	(c) Strength	(d) Units	
29.			
	(c) Strength	(d) Units	

30. Total number of medications in bag..... ☐☐

31. Number of medications in bag unable to successfully scan or transcribe ☐☐

32. HCHS/SOL ID staff number of person scanning / transcribing medications and interviewing the participant:

a. Scanner / transcriber (items 5-29): ..... ☐☐☐

b. Date of scanning / transcription: ..... ☐☐/☐☐/☐☐☐☐
Month Day Year

ID NUMBER:								VERSION: A 08/18/10 Occasion			SEQ #		

C. Medication Use Interview
Ahora me gustaría preguntarle sobre algunos medicamentos específicos.

33. De los medicamentos que usted ha tomado durante las últimas cuatro semanas, ¿fueron algunos para: *(If "Yes", verify that the medication NAME is on the medication record.)*

	No	Sí	Desonocido
a. Asma	0 ☐	1 ☐	9 ☐
b. Bronquitis crónica o enfisema	0 ☐	1 ☐	9 ☐
c. Azúcar alta en la sangre o diabetes	0 ☐	1 ☐	9 ☐
d. Alta presión sanguínea o hipertensión	0 ☐	1 ☐	9 ☐
e. Alto colesterol en la sangre	0 ☐	1 ☐	9 ☐
f. Dolor en el pecho o angina	0 ☐	1 ☐	9 ☐
g. Ritmo cardíaco anormal	0 ☐	1 ☐	9 ☐
h. Falla cardíaca	0 ☐	1 ☐	9 ☐
i. Para hacer su sangre más líquida	0 ☐	1 ☐	9 ☐
j. Embolia cerebral o derrame cerebral	0 ☐	1 ☐	9 ☐
k. Mini-embolia o TIA (por sus siglas en inglés)	0 ☐	1 ☐	9 ☐
l. Dolor en la pierna al caminar o claudicación	0 ☐	1 ☐	9 ☐

34. Durante las últimas cuatro semanas, ¿ha tomado usted algún tipo de aspirina o productos que contengan aspirina, incluyendo Alka-Seltzer, medicamento para la gripe o alergia, o medicamento en polvo para el dolor de cabeza? Esto **no** incluye el acetaminofeno (por ejemplo, Tylenol), ibuprofeno (por ejemplo, Advil, Motrin o Nuprin) y naproxeno (por ejemplo, Aleve).

Show participant List #1: Commonly Used Aspirin or Aspirin-Containing Products

No 0 ☐ → **GO TO QUESTION 37**
Sí 1 ☐
Desconocido 9 ☐ → **GO TO QUESTION 37**

35. Durante las últimas cuatro semanas, ¿cuántos días tomó usted aspirina o un medicamento que contenga aspirina?

☐☐ Número de días

If number of days equals "00" → **GO TO QUESTION 37**

ID NUMBER:									FORM CODE: MDS VERSION: A 08/18/10	Contact Occasion			SEQ #		

36. ¿Con qué propósito está tomando usted aspirina? (*Interviewer: Do NOT read choices to participant.)*
    Participant mentioned "*para evitar ataque al corazón o embolia"* 1 ☐
    Participant did not mention "*para evitar ataque al corazón o embolia"* 2 ☐

37. Durante las últimas cuatro semanas, ¿ha tomado usted algunos [otros] medicamentos que fueron para la artritis, la fiebre, los dolores musculares o los calambres? *(Read bracketed "other" unless no medications were reported.)*
    No 0 ☐
    Sí 1 ☐
    Desconocido 9 ☐

38. **Sin** incluir la aspirina, el acetaminofeno (por ejemplo, Tylenol) y corticosteroides (por ejemplo, la prednisona), ¿está usted tomando AHORA algún otro antiinflamatorio o medicamento para la artritis en forma regular? Ejemplos comunes se muestran en esta lista.

Show participant List #2: Commonly Used Non-Steroidal Anti-Inflammatory Drugs, NSAIDS

No 0 ☐ → **END QUESTIONNAIRE**
Sí 1 ☐
Desconocido 9 ☐ → **END QUESTIONNAIRE**

39. Unless already recorded in Items B5-B29, record the following information for the medication identified by Item 38.

Already recorded 1 ☐

(a) Medication UPC		(b) Medication name
☐☐☐☐☐☐☐☐☐☐☐☐		
(c) Strength	(d) Units	

40. ¿Cuántas pastillas por semana toma usted como promedio?
    ☐☐ Número de pastillas a la semana

41. Staff ID number of person who interviewed the participant: ..... ☐☐☐

Sueño – Sleep Habits in HCHS/SOL

Medication Usage (MDE/MDS) Question by Question Instructions

General Instructions

The purpose of the Medication Survey is to assess medication usage in the four weeks preceding the examination date. Information on both prescription and over-the-counter medications is ascertained via scanning of bar code symbols, transcription of labels, and interview. To obtain this information, the participant is asked prior to the clinic visit to bring to the field center all medications, over-the counter preparations, vitamins, minerals, and dietary supplements taken in the four-week period preceding the visit, or their containers. Notification of this request is mailed to the participant with the written instructions for the exam visit, and is re-stated during the appointment reminder call. Interviewers require certification in interviewing techniques and familiarity with the data entry procedures for electronic and paper versions of the form. Paper data entry and subsequent keying will only be used in the event of equipment malfunction or DMS inaccessibility. Scanners / transcribers of medication information also require certification.

Question by Question Instructions

Administrative Information

Item 0a: Enter the date the participant was seen in the clinic. Use leading zeroes where necessary to fill all boxes. For example, September 3, 2007 would be entered as:

0	9	/	0	3	/	2	0	0	7

Item 0b: The staff person completing this form must enter their three-digit Staff ID number in the boxes provided.

A. Reception
Item 1: Read the question as written.

1. Did you bring all the medications that you used in the past four weeks, or their containers?

Yes, all ..... 1 → **Go to Section B Item 5**
No, Some of them ..... 2 → **Go to Section A, Item 3**
No, None of them 3

If the response is "Yes, all", go to Section B (MEDICATION RECORD) and begin the scanning / transcription. As the participant delivers the medications, indicate where (and by whom) they will be returned before he / she leaves. Mention that medication names will be scanned / copied from the labels, and that if required, medications will be taken out of their container only in the presence of, and with approval of the participant. Finally, indicate that a trained interviewer will later ask a few questions about some specific medications. Do not transcribe medications until the participant has signed the informed consent.

If the response is "Some of them", go to Item 3 to make arrangements for those medications which were not brought and scan / transcribe those medications which were brought in Section B (MEDICATION RECORD).

If the response is "No", proceed to the next item.

Item 2: Read the question as written.

2. Is this because you forgot, because you have not taken any medications at all in the last four weeks, or because you could not bring your medications?

Took no medications.....0 → **Go to Section C, Item 34**
Forgot or was unable to bring medications.....1

If the response is "Took no medications" in the past four weeks, Section A ends here. Leave Section B (MEDICATION RECORD) blank and skip to INTERVIEW, Section C (field or screen forward). Item 33 is left blank, and the interviewer continues administering items 34-40.

If the response is "Forgot or was unable to bring medications", reassure the respondent and proceed to the next item.

Items 3-4: Read item 3 as written. Ideally, follow-up involves the participant returning to the field center with the medications for Scanning / Transcription. Reasonable alternatives to the ideal include recording the medications at the participant's home (especially those sites that will be retrieving the actigraphs from the participant's homes) or telephone interview.

3. May we follow up on this after the visit so that we can get the information from the other medication labels? (Explain follow-up options)

No or not applicable.....0 →
Yes 1

Scan / transcribe what you can in Section B. Attempt to convert refusals and indicate this on tracking form

If the participant agrees to follow-up, make arrangements for obtaining the information Describe the method of follow-up in item 4. If the participant brought some medications, complete as much of Section B (MEDICATION RECORD) as possible before going on to Item 33. If participant follow-up occurs and additional or a complete list of medications are given, make sure to update this form starting with Question 1 in Section A.

In case of deliberate omission to bring medications to the field center, attempt participant conversion. Leave Section B (MEDICATION RECORD) blank if no medications were brought in. Even if the participant declines to bring in (or provide medication names by telephone), attempt to complete as much of Section C (INTERVIEW) as possible. If the participant has not brought his / her medications, but remembers the medication name, strength and units of all medications taken during the previous four weeks with confidence, the interviewer should record this information, but arrange a follow-up to confirm its accuracy.

B. MEDICATION RECORD

Introduction: Section B (MEDICATION RECORD) is designed to document information about each medication used by participants. Bar Code Scanning / Transcription includes recording the Universal Product Code (UPC) / National Drug Code (NDC) in section (a), the name in section (b), the strength in section (c), and the units in section (d) for each medication used within the four weeks prior to the interview.

Medication UPC / NDC, Medication Name, Strength, and Units (Items 5-29a-d)

Overview: Separate the medications into those with and without a UPC-labeled container. Attempt to scan the UPC-labeled containers. Set aside containers that are scanned *successfully* (automatically linked to information in sections [b-d] that matches information on their labels). For medications in UPC-labeled containers that cannot be scanned *successfully* (as defined above), transcribe the UPCs. When UPCs cannot be transcribed *successfully*, transcribe NDCs, if available, or medication names. When NDCs and medication names cannot be transcribed *successfully*, manually transcribe as much information as possible in sections (a-d).

Scanning: A UPC bar code symbol is a pattern of black bars and white spaces, below (or above) which are twelve numbers. In example [1], the first six numbers—614141—comprise the globally unique company prefix assigned by the Uniform Code Council. The next five—54321—comprise the item reference. The last—2—is a computer-generated check digit used to verify accuracy. The symbol encodes all twelve numbers (collectively referred to as the Global Trade Item Number [GTIN]). In this context, we informally refer to the GTIN as a Universal Product Code (UPC). A ten- or eleven-digit National Drug Code (NDC), which by federal law is assigned to all pharmaceuticals sold in the U.S., is often represented within the UPC and recorded elsewhere on medication packaging. Several variations in UPC / NDC spacing, and hyphenation are illustrated in examples [2-3]. Scan the bar code symbol with the wand to capture the UPC / NDC. Rescan it as needed. *EXTREMELY IMPORTANT: JUDGE SUCCESS OF THE SCAN BY VERIFYING THAT THE INFORMATION THAT AUTOMATICALLY POPULATES SECTIONS (B-D) MATCHES INFORMATION ON THE MEDICATION LABEL.*

UPC / NDC: 306030048167 311017110010
Name: Azo-Septic .....Dr. Scholl's Clear Away Plantar

Strength: 95 40
Units: MG %

Transcription: Transcribe all medications without a UPC-labeled container *and* those with a UPC-labeled container that cannot be scanned *successfully* (as defined above). Specifically, in section (a), transcribe the unsuccessfully scanned UPC, if possible. If the UPC cannot be transcribed *successfully*, transcribe the NDC in section (a). The NDC is often recorded elsewhere on the medication packaging. If the NDC cannot be transcribed *successfully* transcribe in section (b) the complete medication name as written on the container. Medication labels may contain standard abbreviations (Table 1). In section (c), transcribe the numeric strength (weight for solids and concentration for non-solids). In section (d), transcribe the units that measure strength using a standard abbreviation (Table 2). Formatting and transcription standards are detailed below.

Table 1. Standard abbreviations of medication names

Medication Name	Abbreviation	Medication Name	Abbreviation	Medication Name	Abbreviation
A Acetaminophen	APAP	Aluminum	AL	Amitriptyline	AMITRIP
Antibiotic	ANTIBIO	Antihistamine	ANTIHIST	Arthritic	ARTHR
Aspirin	ASA	Aspirin, phenacetin & caffeine	APC	Ammononium	AMMON
B Balanced Salt Solution	BSS	Buffered	BUF		
C Caffeine	CAFF	Calcium	CA	Capsules	CAP
Carbonate	CARBON	Chewable	CHEW	Chlordiazepoxide	CHLORDIAZ
Chloride	CL	Chlorpheniramine	CHLORPHEN	Codeine	COD
Compound	CPD or CMP or CMPD	Concentrate	CON		
D Decongestant	DECONG	Dextromethorphan	DM	Dioctylsodium sulfosuccinate	DSS
E Expectorant	EXP	Extra	EX		
F Ferrous	FE	Fluoride	FL	Formula	FORM
G Gluconate	GLUCON	Glyceryl Guacolate	GG	Guaifenesin	GG
H Hydrochloride	HCL	Hydrochlorthiazide	HCTZ	Hydrocortisone	HC
Hydroxide	HYDROX				
I Inhalation	INHAL	Injection	INJ	Intravenous	IV
J Junior	JR				
L Laxative	LAX	Liquid	LIQ	Long acting	LA
Lotion	LOT				
M Magnesium	MG	Maximum	MAX	Minerals	M
Multivitamins	MULTIVIT				
N Nitroglycerin	NTGN				
O Ointment	OINT	Ophthalmic	OPTH		
P Penicillin	PCN	Pediatric	PED	Perphenazine	PERPHEN

Phenobarbitol	PB	Phenylephrine	PE	Phenylpropanolamine	PPA
Potassium	K	Potassium Chloride	KCL	Potassium Iodide	KI
Powder	PWD	Pyrilamine	PYRIL		
R Reliever	REL				
S Simethicone	SIMETH	Sodium	SOD	Solution	SOLN
Strength	STR	Suppository	SUPP	Suspension	SUSP
Sustained action	SA	Sustained release	SR	Syrup	SYR
T Tablets	TAB	Theophyllin	THEOPH	Therapeutic	T
Time disintegration	TD				
V Vaccine	VAC	Vitamin	VIT		
W With	W				

Table 2. Standard abbreviations of metric units

Units	Standard Abbreviation	Units	Standard Abbreviation
Anti-Clotting Factor Xa International Units/Milliliter	A-XA IU/ML	Milligram/Drop	MG/DROP
Billion Cells of Lactobacilli	B CELL	Milligram/Gram	MG/GM
Bioequivalent Allergy Units/Milliliter	BAU/ML	Milligram/Inhalation‡	MG/INH
Actuation*	ACT	Milligram/Hour	MG/HR
Enzyme-Linked Immunosorbent Assay Units/Milliliter	ELU/ML	Milligram/Milligram	MG/MG
Gram†	GM	Milligram/Milliliter	MG/ML
Gram/Dose	GM/DOSE	Milligram/Spray	MG/SPRAY
Gram/Gram	GM/GM	Milligram/Teaspoon§	MG/TSP
Gram/Milliliter	GM/ML	Milliliter	ML
Kallikrien Inactivator Units/Milliliter	KIU/ML	Milliliter/Milliliter	ML/ML
Flocculation Units	LFU	Millimole	MMOLE
Megabecquerels/Milliliter	MBQ/ML	Millimole/Milliliter	MMOLE/ML
Microgram†	MCG	Million International Units	MIU
Microgram/Actuation	MCG/ACT	Million International Units/Milliliter	MIU/ML
Microgram/Hour	MCG/HR	Million Units	MU
Microgram/Inhalation‡	MCG/INH	Million Units/Gram	MU/GM
Microgram/Milliliter	MCG/ML	Million Units/Milliliter	MU/ML
Microgram/Spray	MCG/SPRAY	Minim	MINIM
Microgram/Square Centimeter	MCG/SQCM	Minim/Milliliter	MINIM/ML
Millicuries/Milliliter	MCI/ML	Percent	%
Milliequivalent	MEQ	Plaque Forming Units/Milliliter	PFU/ML
Milliequivalent/Gram	MEQ/GM	Protein Nitrogen Units/Milliliter¶	PNU/ML
Milliequivalent/Liter	MEQ/L	Unit	UNIT
Milliequivalent/Milligram	MEQ/MG	Unit/Actuation	UNIT/ACT
Milliequivalent/Milliliter	MEQ/ML	Unit/Gram	UNIT/GM

Milligram†	MG	Unit/Milligram	UNIT/MG
Milligram/Actuation	MG/ACT	Unit/Milliliter	UNIT/ML

*Actuation = activation of a dispensing de vice. †1 GM = 1000 MG; 1 MG = 1000 MCG. ‡Of aerosolized powder. §Of e.g. powdered or granulated oral medications. ¶Of allergenic extracts.

Standard Format: Beginning with item 5, transcribe the numeric UPC / NDC (a) working from the right-most box. Transcribe all parts of each medication name as written on the container (b), numeric strength (c), and standard units (d). If using the paper form, carefully transcribe medication name and units in UPPER CASE CHARACTERS (CAPITAL LETTERS). When necessary, use a period (.) to indicate the location of a decimal point in strength and a forward slash (/) to separate active ingredients of generic products, their respective strengths and units. In every case, transcribe in standard format even when the same information or a portion of the information appears in the previous item. Do not use ditto marks (") to indicate a repeat of the previous item.

Medication UPC / NDC (Items 5-29a): Transcribe the UPC / NDC when it cannot be scanned *successfully* (as defined above). Be sure to transcribe the first and last numbers of the UPC which may be found in the lower (middle or upper) left and right regions of the UPC bar code symbol (e.g. 6 and 2 in example [1], above).

Medication Name (Items 5-29b): Transcribe the medication name using a forward slash (/) to separate active ingredients of generic medications. *EXTREMELY IMPORTANT: DO NOT TRANSCRIBE E.G. MANUFACTURER NAME, FLAVOR, WHETHER MEDICATIONS ARE SUGAR-FREE, OR LOW-SODIUM.* Since a few companies have trademarked their formulation (dosage form), the complete medication name may include it. Although we do not transcribe the number of pills dispensed, the prescribed dose, actual dose, or frequency of medications taken, medication names also may include numbers or characters that can be mistaken for number dispensed, dose or frequency. If in doubt, it is preferable to include questionable information in the medication name to facilitate identification, coding and classification. Therefore, transcribe all formulations, numbers and characters that may be part of the medication name. Examples are provided in Table 3. Standard abbreviations of medication names were provided in Table 1 (above).

Table 3. Examples of medication names that include special formulations, numbers or characters

Medication Name	
DILANTIN KAPSEALS*	ORTHO-NOVUM 10/11-28
ASA ENSEALS†	STUARTNATAL 1 + 1
ANACIN-3	NPH ILETIN I
ACEROLA-C	SK-AMPICILLIN
TRIAMINIC-12	CALTRATE 600 PLUS VITAMIN D
OVRAL-28	HCTZ/TRIAMTERENE‡

*Kapseals = capsules. †Enseals = enteric-coated capsules. ‡The "/" separates HCTZ (hydrochlorothiazide) and triamterene, two active ingredients.

Strength (Items 5-29c): The strength of most solid medications is given in number of milligrams. Transcribe the numeric strength (weight for solids and concentration for non-solids) using a period (.) to indicate the location of a decimal point and a forward slash (/) to separate the strength of active ingredients of generic products (e.g. medication name = HCTZ/TRIAMTERENE, strength = 25/37.5).

Units (Items 5-29d): Transcribe the metric units that measure strength using one of the standard abbreviations in Table 2 (continuing the above example, units = MG/MG). Prior metric conversion of non-standard units (e.g. for liquids: 1 fluid ounce = 30 ML; 1 tablespoon = 15 ML; 1 teaspoon = 5 ML; and for solids: 1 grain = 65 MG; 1 ounce = 31 GM) may be necessary in unusual cases. Note that for insulin, strength is often given in number of units per milliliter (e.g. 100U/ML, 100/ML and U100). All three of these non-standard abbreviations are equivalent to the preferred format (strength = 100; units = UNIT/ML).

Combination Medications: Combination medications contain multiple active ingredients (two or more medications in a single formulation). For example, consider a brand name combination of HCTZ 25 MG and TRIAMTERENE 37.5 MG called DYAZIDE. In the U.S., it is sold only in this fixed combination. Because fixed combination medications do not generally list a strength (c) or units (d), these fields may be left blank when transcribing them (i.e. medication name = DYAZIDE; strength = _[blank]_ ; units = __[blank]__). Other combination medications are sold in more than one fixed combination. For example, consider a brand name combination of HCTZ and PROPRANOLOL called INDERIDE (LA). In the U.S., it is sold in many different combinations (HCTZ 25 or 50 MG and PROPRANOLOL 40, 80, 120 or 160 MG). Because variable combination medications generally list the strength and units, complete these fields when transcribing them (i.e. medication name = INDERIDE; strength =25/40 or 25/80; units = MG/MG; or medication name = INDERIDE LA; strength = 50/80, 50/120 or 50/160; units = MG/MG).

Examples: Feosol Iron Supplement Therapy 45 mg

#	(a) Medication UPC / NDC													Medication name (b)
5.	**3**	**4**	**9**	**6**	**9**	**2**	**9**	**4**	**1**	**6**	**0**	**5**		FEOSOL IRON SUPPLEMENT THERAPY
	(c) Strength						(d) Units							
	45						MG							

Lipitor 10 mg

#	(a) Medication UPC / NDC													Medication name (b)
6.	**3**	**0**	**0**	**7**	**1**	**0**	**1**	**5**	**5**	**2**	**3**	**7**		LIPITOR
	(c) Strength						(d) Units							
	10						MG							

Regular Strength Tylenol 325 mg

#	(a) Medication UPC / NDC													Medication name (b)
7.	**5**	**0**	**5**	**8**	**0**	**4**	**9**	**6**	**6**	**0**				REGULAR STRENGTH TYLENOL
	(c) Strength						(d) Units							
	325						MG							

Neosynephrine Regular Strength ½ percent

#	(a) Medication UPC / NDC													Medication name (b)
8.	**3**	**0**	**0**	**2**	**4**	**1**	**3**	**5**	**3**	**0**	**1**	**0**		NEOSYNEPHRINE REGULAR STRENGTH
	(c) Strength							(d) Units						
	0.5							%						

Metamucil 3.4 g per dose

#	(a) Medication UPC / NDC													Medication name (b)
9.	**0**	**3**	**7**	**0**	**0**	**0**	**7**	**4**	**0**	**7**	**8**	**0**		METAMUCIL
	(c) Strength							(d) Units						
	3.4							G/DOSE						

Robitussin 100 mg per teaspoon

#	(a) Medication UPC / NDC													Medication name (b)
10.	**3**	**0**	**0**	**3**	**1**	**8**	**6**	**2**	**4**	**1**	**2**	**8**		ROBITUSSIN
	(c) Strength							(d) Units						
	100/5							MG/ML						

Magnesium Citrate Solution 1.745 g per ounce

#	(a) Medication UPC / NDC													Medication name (b)
11.	**8**	**4**	**0**	**9**	**8**	**6**	**0**	**1**	**0**	**2**	**5**	**5**		MAGNESIUM CITRATE SOLUTION
	(c) Strength							(d) Units						
	1.745/30							G/ML						

Prioritizing Transcription: Polypharmacy tends to increase with age, but even if a participant is using more than 25 medications, only 25 can be transcribed in items (5-29). Therefore, prioritize transcription if there are more than 25 medications. If it is clearly necessary to defer prioritization, transcribe the UPC (a), name (b), strength (c), and units (d) of additional medications on the back of the last page of the form. Deferral may allow more effective prioritization based on the number and type of medications available for transcription. In any case, use the following algorithm to guide prioritization: [1] prescription medications; then [2] aspirin, aspirin-containing medications and non-steroidal anti-inflammatory drugs (e.g. Alka-Seltzer, headache powders, cold or arthritis medications, et cetera); followed by [3] other over-the-counter preparations; and finally [4] vitamins and food supplements.

The Medication Dictionary: For reference, paper versions of the Medication Dictionary will be distributed to each Field Center. The dictionary lists medication names (trade / brand and generic ingredient) in alphabetical order. Medication names that begin with a number, ditto ("), or a hyphen (-) are listed first. If a medication name is separated by a hyphen (-), the portion of the name preceding the hyphen is listed in alphabetical order. Strength and units are not included in the dictionary, so only use the numbers appearing in it to differentiate between medications.

Preparing to Use the Medication Dictionary: Before using the medication dictionary to look up a

medication, first check the spelling of its transcribed name against its container's label. Verify that numbers referring to quantity dispensed, dose, or frequency were not inappropriately transcribed as part of the medication name because they should not be used in the matching process. Be aware that while some pharmacists use standardized abbreviations (Table 1, above) others do not. Also be aware that some medications use suffixes to distinguish between different combinations containing the same primary ingredient (Table 4).

Table 4. Examples of medication suffixes used to distinguish combinations

Medication Name	1° Ingredient	2° Ingredients	
DARVON	propoxyphene hydrochloride		
DARVON N	propoxyphene napsylate		
DARVON W ASA	propoxyphene hydrochloride	aspirin	
DARVON CMPD	propoxyphene hydrochloride	aspirin	caffeine

Using the Medication Dictionary: Use the dictionary as needed to look up medications (that when scanned or transcribed) do not automatically populate sections [a-d] with an appropriate match or list of potential matches from which to choose. For medication names containing more than one word, look for a match of the complete medication name in the dictionary. If the complete name matches, enter the corresponding UPC. If a complete match cannot be found, but the dictionary contains a single entry for the ingredient(s) in the medication (usually the first word of the medication name), and there are no other entries containing this word, select the corresponding UPC. This often occurs when [1] the brand *and* generic medication name are transcribed, but only one is in the dictionary; [2] the formulation of the medication is transcribed, but is not in the dictionary; [3] the manufacturer name is transcribed, but is not in the dictionary; or [4] words referring to other ingredients are transcribed, but are not in the dictionary or are in the dictionary in a different order (Table 5). *EXTREMELY IMPORTANT: IF A MEDICATION NAME IS NOT IN THE DICTIONARY, DO NOT GUESS AT A MATCH. SIMPLY SET THE STATUS CODE TO Q (QUESTIONABLE) SO THAT THE COLLABORATIVE STUDIES COORDINATING CENTER CAN INVESTIGATE.*

Table 5. Examples of medication names that may not automatically populate sections [a-d]

Medication Name Transcribed As	Reason For Failure	Re-Transcribe As
CORDARONE/AMIODARONE	CORDARONE is the brand name for AMIODARONE	AMIODARONE
DIMETAPP ELIXIR	ELIXER is the formulation	DIMETAPP
ECKERD ALLERGY RELIEF TABS	ECKERD is the manufacturer	ALLERGY RELIEF
TYLENOL NO. 3	NO. 3 refers to another active ingredient (codeine)	APAP W CODEINE

Items 30-31: Once all medications that can be successfully scanned or transcribed have been processed, count the total number of different medications (including those that cannot be successfully scanned or transcribed). Item 30 mentions the total number of medications in the bag. The parent study sent bags for the participants to put their medications in when they reported for their visit. However, Sueño is not providing bags to the participants so the "bag" part of the question can be ignored. Enter the total number of medications that were brought into the visit in Item 30. Set aside loose pills, containers that are unmarked, unclearly labeled, or hold more than one medication (e.g. medisets), if necessary in consultation with another trained staff person, for later examination by a trained interviewer. Add the number of medications that you are unable to successfully scan or

transcribe. Enter this number in Item 31. For example, if there were 7 medications brought in by the participant, and you were able to successfully scan or transcribe 5 of them, Items 30 and 31 would be completed as follows:

30. Total number of medications in bag ..... | 0 | 7 |

31. Number of medications unable to successfully scan or transcribe… | 0 | 2 |

Items 32a,b: The staff person scanning / transcribing the medications must enter their three-digit HCHS/SOL Staff ID number in item 32a and the date of medication scanning / transcription in item 32b. If necessary, make a note on the Medication Survey Form, and inform the participant that a trained interviewer will ask for help identifying loose pills and medications in containers that are unmarked, unclearly labeled, or hold more than one medication. *EXTREMELY IMPORTANT: AT NO TIME SHOULD MEDICATIONS BE LEFT UNATTENDED IN THE RECEPTION AREA OR MEDICATION CONTAINERS BE OPENED IN THE ABSENCE OF THE PARTICIPANT.*

C. MEDICATION USE INTERVIEW

Identifying Unknown Medications: Determine from Item 31 on the form at the end Section B whether there are any medications that were not successfully scanned or transcribed including loose pills, medications in containers that are unmarked, unclearly labeled, or hold more than one medication. With the participant's help, read the imprint(s) on each unknown pill, then search [1] the *Facts and Comparisons Drug Identifier* on your computer, or if necessary, [2] the *Ident-A-Drug,Reference* on the web (**www.identadrug.com**; username=_____; password=_____) to identify each pill from its imprint(s), shape, and / or color. If possible, record the UPC / NDC (a) or medication name (b) and if not transcribed *successfully* (as defined above), its strength (c) and units (d). If the medication cannot be identified, record UNKNOWN and the imprint(s) under medication name (b) and draw two horizontal lines (=) through the boxes for the UPC / NDC (a). If additional medications can be identified and recorded, adjust the total for item 31 accordingly. Thereafter, probe the participant about any other medications that may have been taken in the previous four weeks. For additional medications recalled by the participant, record with as much detail as possible the medication name (b), and if not automatically linked to information in sections [c-d] that matches information provided by the participant, strength (c), and units (d). If there is any doubt, arrange for follow-up to obtain more accurate information from the participant.

During the remainder of the Medication Survey interview or during a subsequent interview, the participant may recall other medications taken during the past four weeks. Transcribe the medication UPC (a), name (b), strength (c) and units (d) of each just as if they had been brought in. However, do not adjust the total for item 31. This documents that information on some medications was provided from the participant's memory.

Items 33a-l: Following the transition statement provided, ask if medications were taken in the past four weeks for the twelve listed reasons. Synonyms that may be used in response to participant questions are listed parenthetically and below (Table 6).

Table 6. Synonyms that may be used in response to participant questions about items 33a-k

Question text	Synonyms
a. Asthma	
b. Chronic bronchitis or emphysema	Chronic obstructive pulmonary disease or COPD
c. High blood sugar	Diabetes
d. High blood pressure	Hypertension
e.High blood cholesterol	Hypercholesterolemia
f. Chest pain	Angina
g. Abnormal heart rhythm	Arrhythmia
h. Heart failure	Congestive heart failure or CHF
i. Blood thinning	Anticoagulation
j. Stroke	Cerebrovascular accident or CVA
k. Mini-stroke	Transient ischemic attack or TIA
l. Leg pain while walking	Claudication or peripheral arterial disease or PAD

For example, if the participant had taken medication for asthma and claudication and no other listed conditions, code item 33 as follows:

	Yes	No	Unknown
a. Asthma	(Y)	N	U
b. Chronic bronchitis or emphysema (chronic obstructive pulmonary disease [COPD])	Y	(N)	U
c. High blood sugar (diabetes)	Y	(N)	U
d. High blood pressure (hypertension)	Y	(N)	U
e. High blood cholesterol (hypercholesterolemia)	Y	N	(U)
f. Chest pain (angina)	Y	N	(U)
g. Abnormal heart rhythm (arrhythmia)	Y	(N)	U
h. Heart failure (congestive heart failure [CHF])	Y	(N)	U
i. Blood thinning (anticoagulation)	Y	(N)	U
j. Stroke (cerebrovascular accident [CVA])	Y	(N)	U
k. Mini-stroke (transient ischemic accident [TIA])	Y	(N)	U
l. Leg pain while walking (claudication or peripheral arterial disease [PAD])	(Y)	N	U

If any of the conditions are answered affirmatively, be sure that the medication is recorded in Section B by asking "Did we include that medicine in the list I just transcribed?". DO NOT ask the participant to identify which medication was used to treat any of the conditions. For example, if the participant reported taking a medication to lower blood pressure during the last two weeks (Item 33a), and no recognized antihypertensive medications were recorded in Section B, DO NOT probe to determine if the names of all medications taken during the last two weeks were recorded. If the participant indicates that the names of all his / her medications have been transcribed, DO NOT probe further to determine which medication was used to treat the high blood pressure. Regardless of whether the participant reported taking any medications during the past four weeks or whether they brought any medication to the field center, proceed with the next item.

Item 34: If skipping in from Item 2, preface this question with an explanation e.g. *"I know you said you took no medications, but we include the next few questions as a memory jogger."* Then ask the question as worded and show participant List #1: Commonly Used Aspirin or Aspirin-Containing Medications. Although its primary purpose is to identify participants who are taking aspirin, item 34 is broadly constructed to include aspirin and other medications which may contain aspirin but are not necessarily labeled as aspirin, such as "Alka-Seltzer, cold medicine or headache powder". Therefore, this question may identify persons taking medications that do not include "aspirin", per se. With a positive response, continue with item 35 and verify that the relevant information on the medication(s) was recorded in Items 5-29. If the response is NO or UNKNOWN, skip to item 37.

Item 35: Item 35 is narrower in scope and refers specifically to aspirin or aspirin-containing medications that have been taken within the four weeks preceding the clinic visit. Record the number of days in this four week period (maximum of 28 days) that aspirin or aspirin-containing medications were taken. If no aspirin or aspirin-containing medications were taken, enter "00" and skip to Item 37.

Item 36: Ask item 36 as written, but DO NOT READ THE CHOICES. If the participant mentions avoiding heart attack or stroke as part of his / her response, record "1". Participants could be following the advice of their provider of medical care in doing this, or they could be acting on their own, based on information obtained through the media, friends or other sources. If the participant mentions "blood

thinning" or avoiding blood clots as the reason for taking aspirin, record "1". If neither a heart attack nor stroke is mentioned, record "2", even if the aspirin were prescribed by a physician.

Item 37: Read item 37 to all participants following the instructions provided at the end of the question, i.e., read the bracketed "other" if the response to Item 34 was "Yes". The use of analgesic and anti-inflammatory medications that do not contain aspirin is verified because these medications (like aspirin) may affect some of the hemostasis tests. With a "Yes" response, confirm whether the reported medications are transcribed in Section B.

Item 38-40: Read item 38 to all participants and show them List #2: Commonly Used Non-Steroidal Anti-Inflammatory Drugs (NSAIDS), the most common, non-aspirin-containing treatments for arthritis. Item 38 excludes acetaminophen (e.g. Tylenol) and aspirin (as separate entities) as well as steroids. This item focuses on current, regular use (NOW) of NSAIDS, regardless of the reason for their use. If asked by the participant, "regular" is defined as at least once a week for several months. If the response is "No" or "Unknown", go to closing. If the response is "Yes", continue by completing Item 39 (unless already recorded in Section B) and Item 40 (in response to the question, "How many pills per week are you taking on average?")

Item 41: The staff person who interviewed the participant must their three-digit HCHS/SOL Staff ID number in item 41.

List #1: Commonly Used Aspirin-Containing Medications (3 page list, page 1)

1/2HALFPRIN
ACETAMINOPHEN / MAGNESIUM SALICYLATE / CAFFEINE
ACETAMINOPHEN / SALICYLAMIDE
ACETAMINOPHEN / SALICYLAMIDE / CAFFEINE
ACETAMINOPHEN / SALICYLAMIDE / PHENYLTOLOXAMINE
ACETYL SALICYLIC ACID
ADDED STRENGTH HEADACHE R
ADDED STRENGTH PAIN RELIE
ADPRIN B
ADULT STRENGTH ANALGESIC
ADULT STRENGTH PAIN RELIE
AF-MIGRAINE
ALBERTSON'S EFFERVESCENT
ALBERTSON'S ENTERIC COATE
ALBERTSON'S HEADACHE FORM
ALKA-SELTZER
AMIGESIC
ANABAR
ANACIN
ANALGESIC
ACETAMINOPHEN / SALICYLAMIDE / PHENYLTOLOXAMINE / CAFFEINE
ARTHRITIS PAIN FORMULA
ARTHRITIS STRENGTH BC
ARTHROPAN
ASA
ASCRIPTIN
ASP
ASPERGUM
ASPIR-81
ASPIRCAF
ASPIRIN / ANTACID
ASPIRIN / CAFFEINE
ASPIRIN / ACETAMINOPHEN / CAFFEINE
ASPIRIN / ALUMINUM HYDROXIDE / MAGNESIUM HYDROXIDE / CALCIUM CARBONATE
ASPIRIN / ALUMINUM HYDROXIDE / MAGNESIUM HYDROXIDE
ASPIRIN / ACETAMINOPHEN / CAFFEINE / CALCIUM GLUCONATE
ASPIRIN / ACETAMINOPHEN / SALICYLAMIDE / CAFFEINE
ASPIRIN / CAFFEINE
ASPIRIN / CAFFEINE / BUTALBITAL
ASPIRIN / CA CARBONATE
ASPIRIN / CINNAMEDRINE / CAFFEINE
ASPIRIN / SALICYLAMIDE / CAFFEINE
ASPIR-LOW
ASPIR-MOX
ASPIRTAB
ASPIR-TRIN
ASPRIDROX
BACK PAIN-OFF
BACKACHE MAXIMUM STRENGTH
BACKACHE RELIEF EXTRA STR
BAYER LOW STRENGTH
BAYER PLUS EXTRA STRENGTH
BC
BL MIGRAINE FORMULA
BUFFASAL
BUFFERIN
BUFPIRIN
BUTALBITAL / ASA / CAFFEINE
BUTALBITAL / ASPIRIN / CAFFEINE
BUTALBITAL COMPOUND

ASPIRIN
ASPIRIN GUM
ASPIRIN / DIPHENHYDRAMINE EFFERVESCENT
CETAZONE-T
CHOLINE / MAGNESIUM SALICYLATES
CHOLINE MAGNESIUM TRISALICYLATE

List #1: Commonly Used Aspirin-Containing Medications (3 page list, page 2)

CHOLINE SALICYLATE
CMT
COPE
CVS BACKACHE RELIEF
CVS EFFERVESCENT ANTACID
CVS HEADACHE RELIEF
CVS MIGRAINE RELIEF
DEWITT'S PILLS
DIFLUNISAL
DISALCID
DOAN'S
DOLOBID
DOLOREX
DURABAC
DURAXIN
EASPRIN
ECASA
ECK MIGRAINE RELIEF
ECOTRIN
ECPIRIN
ED-FLEX
EFFERVESCENT ANTACID / PAIN
EFFERVESCENT PAIN RELIEF
EFFERVESCENT PAIN RELIEVE
EQUAGESIC
EXCEDRIN
GENACOTE
GOODY'S
HALFPRIN
HCA PAIN RELIEVER
HEADACHE FORMULA ADDED ST
HEADACHE RELIEF
HEADRIN EX STRENGTH PAIN
HM ADULT ANALGESIC
LEVACET
LOBAC
MAGAN
MAGNAPRIN
MAGNESIUM SALICYLATE
MAGNESIUM SALICYLATE / ACETAMINOPHEN
MAGNESIUM SALICYLATE / DIPHENHYDRAMINE
MAG-PHEN
MAGSAL
MEDI-SELTZER
MEPROBAMATE / ASPIRIN
MIDOL MAXIMUM STRENGTH
MIGRAINE FORMULA
MIGRAINE RELIEF
MINITABS
MOBIDIN
MOBIGESIC
MOMENTUM MUSCULAR BACKACH
OSCO ADDED STRENGTH PAIN
OSCO ANALGESIC ADULT STRE
OSCO EFFERVESCENT ANTACID
OSCO LOW STRENGTH ENTERIC
P-A-C
PAIN RELIEF
PAIN RELIEF EXTRA STRENGT
PAIN RELIEF EXTRA STRENGT
PAIN RELIEVER ADDED STREN
PAIN RELIEVER PLUS
PAINAID
PAIN-OFF
PANRITIS FORTE
PHENYLTOLOXAMINE / MAGNESIUM SALICYLATE
PIROSAL
QC PAIN RELIEVER PLUS
RA ANTACID PAIN RELIEF
RA MIGRAINE RELIEF
RID-A-PAIN COMPOUND
SALETO
SALICYLAMIDE / CAFFEINE
SALFLEX
SALSALATE
SAV-ON ADDED STRENGTH PAI
SAV-ON ANALGESIC ADULT ST
SAV-ON BACKACHE RELIEF EX

EX-PAIN	MONO-GESIC	SAV-ON EFFERVESCENT ANTAC
EXTRA STRENGTH BAYER	MP ENCOPRIN	SB BACKACHE EXTRA STRENGT
EXTRAPRIN	MP REGRIPRIN	SB EFFRSCENT ANTACID/PAIN
FARBITAL	MST 600	SB LOW DOSE ASA EC
FIORINAL	MYOGESIC	SB MENSTRUAL
FORTABS	NEUTRALIN	SB PAIN RELIEF F/ACT
FRENADOL	NINOPRIN	SB PAIN RELIEF X-STR
GENACED	NOVASAL	SG EFFERVESCENT ANTACID/P

List #1: Commonly Used Aspirin-Containing Medications (3 page list, page 3)

SG PAIN RELIEVER ADDED ST	SUPAC	UNI-TREN
SM HEADACHE ADDED STRENGT	SUPER STRENGTH PAIN RELIE	VANQUISH
SM HEADACHE PAIN RELIEVER	SUREPRIN	V-R EFFERVESCENT PAIN REL
SOBA ANALGESIC	TETRA-MAG	ZEE-ZELTZER
SOBA PAIN RELIEVER HEADAC	THERAPY BAYER	ZORPRIN
SODIUM SALICYLATE	THIOCYL	
ST JOSEPH ADULT	TRICOSAL	
STANBACK	TRILISATE	

List #2: Commonly Used Non-Steroidal Anti-Inflammatory Drugs (NSAIDS)

ACTRON	KETOPROFEN
ADDAPRIN	KETOROLAC
ADVANCED PAIN RELIEF	LANSOPRAZOLE / NAPROXEN
ADVIL	LODINE
ALEVE	MECLOFENAMATE
ALL DAY RELIEF	MEDI-PROFEN
ANAPROX	MEDIPROXEN
ANSAID	MEFENAMIC ACID
ARTHROTEC	MELOXICAM
BEXTRA	MENADOL
CATAFLAM	MIDOL
CELEBREX	MOBIC
CELECOXIB	MOTRIN
CLINORIL	NABUMETONE
CVS INFANTS' CONCENTRATED	NALFON
DAYPRO	NAPRELAN
DICLOFENAC	NAPROSYN
DICLOFENAC / MISOPROSTOL	NAPROXEN
DYSPEL	NUPRIN
ELIXSURE	ORUDIS
ETODOLAC	ORUVAIL
FELDENE	OXAPROZIN
FENOPROFEN	PHENYLBUTAZONE
FLURBIPROFEN	PIROXICAM
GENPRIL	PONSTEL
HALTRAN	PREVACID / NAPRAPAC
IBU	PROFEN
IBU-DROPS	PROVIL
IBUPROFEN	Q-PROFEN
IBUTAB	RELAFEN
INDOCIN	ROFECOXIB
INDOMETHACIN	RUFEN
I-PRIN	SULINDAC
TAB-PROFEN	VALDECOXIB
TOLECTIN	VIOXX
TOLMETIN	VOLTAREN
TORADOL	

Appendix III - Anthropometry.....46

A. Anthropometry Form (APE).....47
B. Anthropometry QxQ.....48

Anthropometry Form
HCHS/SOL Sleep Ancillary Study

ID NUMBER: ☐☐☐☐☐☐☐☐
Acrostic

FORM CODE:
VERSION: 09/17/10

Contact Occasion ☐☐ SEQ # ☐☐

ADMINISTRATIVE INFORMATION

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

0b. Staff ID: ☐☐☐

Instructions: Complete the measurements below and record any notes.

1. Do you have an electronic implantable device (pacemaker, defibrillator, etc.)?
   - No 0 ☐
   - Yes 1 ☐ **DO NOT PERFORM BIA, WEIGH IN WEIGHT ONLY MODE, SKIP Q5-Q9.**

2. Assessment of ability to stand (choose one):
   - Can stand erectly on both feet. 1 ☐
   - Can stand on both feet, but posture not erect. 2 ☐
   - Cannot stand on both feet. 3 ☐ END QUESTIONNAIRE

3. Standing height (round to nearest cm): ☐☐☐ cm

4. Weight: ☐☐☐.☐ kg

5. Fat (%): ☐☐.☐ %

6. Impedance: ☐☐☐ Ohms

7. Fat mass: ☐☐☐.☐ kg

8. Lean body mass (FFM): ☐☐☐.☐ kg

9. Total body water (TBW): ☐☐☐.☐ kg

10. Notes: _____

_____

Sueño – Sleep Habits in HCHS/SOL

Anthropometry (APE) Question by Question Instructions

General Instructions:
Anthropometry consists of assessing the participant's height, weight and body composition measurements. These measurements are used to assess the relationship between obesity and sleep problems. The APE form records presence of an electronic implantable device (EID), ability to stand, height, weight and bio-impedance output values from the Tanita scale. As the technician progresses through the examination procedures, they will record (or directly enter) the measurements into the APE form. They will then record any reason why the any measurements were not obtained or any notes that may be applicable (if the subject has a prosthetic, etc). Take care that the specific anthropometric guidelines outline in the Sueño MOP are followed each time measurements are recorded on the APE form.

Question by Question Instructions:

Q1 Ask participant if they have an electronic implantable device (EID) (examples of EID's are pacemakers or defibrillators). If participants ask what an EID is you can explain that it is a device that uses electricity to help your body function properly, such as a pacemaker. Other less common EIDs are spinal cord stimulators and deep brain stimulators. Assessing the presence of an EID is important because it is dangerous to perform BIA (Q5-Q9) on people that have these devices. If a person does have an EID then they must be weighed in the Weight Only mode. Please see Sueño MOP for instructions on this procedure.

Q2 This questions whether the participant can stand for the anthropometry measurements. If you directly observe that the participant walked without assistance to the area where the anthropometry equipment is located, then this question does not need to be verbalized. Instead, the technician can make their assessment from the participant's mobility. If the participant did not walk without assistance, then the interviewer should ask participant if they are able to stand without assistance. If they cannot stand, record this on Q2 and end the anthropometry section of the study visit. If they can, assess if they stand erect on both feet when they stand for the height measurement. If the participant cannot stand erect, record this and make note of the circumstances in the notes section (Q10).

Q3-Q9 Measure the participant's height, weight and body composition measurements using the methods outlined in the Sueño MOP. Keep in mind that if the person has an EID, they should be weighed in the Weight Only mode and the measurements listed in Q5-Q9 will not be obtained.

Q10 Record any notes that may be relevant. If it was indicated in Q2 that the person could not stand erect, describe circumstances. If the person has a cast that could not be easily removed and weight and BIA measurements were not obtained make note of this. If the person have a prosthetic limb please make note of this.

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

Medical History Questionnaire
HCHS/SOL Sleep Ancillary Study

ID NUMBER: ☐☐☐☐☐☐☐☐ FORM CODE: MQE VERSION: A 08/10/10 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. If age onset is unknown enter the special missing value, "==", in the item.

Do you have any of the following conditions?

1. Has a doctor ever said that you have high blood pressure or hypertension?

No 0 ☐
Yes 1 ☐ → FOR WOMEN: GO TO QUESTION 1a

1a. Was this during pregnancy only?

No 0 ☐
Yes 1 ☐

2. Has a doctor ever said that you have angina?

No 0 ☐
Yes 1 ☐

3. Has a doctor ever said that you had a heart attack?

No 0 ☐
Yes 1 ☐

4. Has a doctor ever said that you had heart failure?

No 0 ☐
Yes 1 ☐

5. Has a doctor ever said that you had some other kind of heart problem?

No 0 ☐
Yes 1 ☐
If yes, please specify:_____

6. Have you ever had a balloon angioplasty, a stent, or bypass surgery to the arteries in your heart to improve the blood flow to your heart?

No 0 ☐
Yes 1 ☐

ID NUMBER:								FORM CODE: MQE VERSION: A 08/10/10	Contact Occasion			SEQ #			

7. Has a doctor ever said that you had a stroke?

No 0 ☐
Yes 1 ☐

8. Has a doctor ever said that you had a mini-stroke or TIA (transient ischemic attack)?

No 0 ☐
Yes 1 ☐

9. Have you had a balloon angioplasty or surgery to the arteries of your neck to prevent or correct a stroke?

No 0 ☐
Yes 1 ☐

10. Has a doctor ever said that you have an aortic aneurysm, an AAA, or ballooning of your aorta?

No 0 ☐
Yes 1 ☐

11. Has a doctor ever said that you have peripheral arterial disease (problems with circulation, blocked arteries to the legs)?

No 0 ☐ → GO TO QUESTION 13
Yes 1 ☐

12. Have you had an operation, a balloon angioplasty, a stent, or an amputation for this condition?

No 0 ☐
Yes 1 ☐

13. Has a doctor ever said that you have diabetes (high sugar in blood or urine)?

No 0 ☐ → GO TO QUESTION 14
Yes 1 ☐

13a. At what age were you first told this?

☐☐ Age in years

13b.FOR WOMEN: Was this during pregnancy only?

No 0 ☐
Yes 1 ☐

13c. Are you being treated with insulin?

No 0 ☐ → GO TO QUESTION 14
Yes 1 ☐

13d. Was insulin the first medicine used for diabetes?

No 0 ☐
Yes 1 ☐

ID NUMBER:									FORM CODE: MQE VERSION: A 08/10/10	Contact Occasion			SEQ #			

14. Have you ever been told by a doctor that you had a sleep disorder?

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

15. Which sleep disorder(s)?

	NO	YES	
a. Insomnia	0 ☐	1 ☐	
b. Restless legs	0 ☐	1 ☐	
c. Narcolepsy	0 ☐	1 ☐	
d. Apnea	0 ☐	1 ☐	→ IF RESPONSE TO Q15d IS "YES", ASK Q15d.1.
e. Other	0 ☐	1 ☐	

If other, please specify:_____

➔ **15d.1. Have you been prescribed a CPAP or BIPAP machine, or a device to wear in your mouth to treat your sleep apnea?**

No 0 ☐
Yes 1 ☐

Medical History Questionnaire_Spanish
HCHS/SOL Sleep Ancillary Study

ID NUMBER:									FORM CODE: MQS VERSION: A 09/01/10	Contact Occasion			SEQ #		

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. If age onset is unknown enter the special missing value, "==", in the item.

¿Tuvo usted algunas de las siguientes enfermedades?

1. ¿Alguna vez le ha dicho un doctor que usted tiene presión sanguínea alta o hipertensión?
   No 0 ☐
   Sí 1 ☐ → FOR WOMEN: GO TO QUESTION 1a

   1a. ¿Sucedió esto durante el embarazo solamente?
   No 0 ☐
   Sí 1 ☐

2. ¿Alguna vez le ha dicho un doctor que usted tiene angina de pecho?
   No 0 ☐
   Sí 1 ☐

3. ¿Alguna vez le ha dicho un doctor que usted tuvo un ataque al corazón?
   No 0 ☐
   Sí 1 ☐

4. ¿Alguna vez le ha dicho un doctor que usted tuvo insuficiencia cardiaca o falla cardiaca?
   No 0 ☐
   Sí 1 ☐

5. ¿Alguna vez le ha dicho un doctor que usted tuvo algún otro problema del corazón?
   No 0 ☐
   Sí 1 ☐
   Si "sí", por favor especifique: _____

6. ¿Le han hecho procedimientos como angioplastia con balón, (para dilatarle los vasos del corazón), o le han puesto un "stent", o le han hecho cirugía de bypass del corazón?
   No 0 ☐
   Sí 1 ☐

ID NUMBER:								FORM CODE: MQS VERSION: A 09/01/10	Contact Occasion			SEQ #			

7. ¿Alguna vez algún doctor le ha dicho que usted tuvo un derrame cerebral, apoplejía, o ataque cerebral?

No 0 ☐
Sí 1 ☐

8. ¿Alguna vez le ha dicho un doctor que usted tuvo un derrame (ataque) cerebral pequeño o transitorio conocido como TIA en inglés?

No 0 ☐
Sí 1 ☐

9. ¿Le han hecho una angioplastia con balón (dilatación) o cirugía de las arterias del cuello para prevenir o corregir una apoplejía o derrame (ataque) cerebral?

No 0 ☐
Sí 1 ☐

10. ¿Alguna vez le ha dicho un doctor que usted tiene o tuvo un aneurisma en la aorta, un aneurisma aórtico abdominal (AAA, por sus siglas en ingles) o dilatación de su aorta?

No 0 ☐
Sí 1 ☐

11. ¿Alguna vez le ha dicho un doctor que usted tiene enfermedad arterial periférica (problemas con la circulación, arterias bloqueadas en sus piernas)?

No 0 ☐ → GO TO QUESTION 13
Sí 1 ☐

12. ¿Ha tenido usted un “bypass”, una angioplastia con balón, le han puesto un “stent”, o le han amputado una extremidad (pierna o pie) debido a esta condición?

No 0 ☐
Sí 1 ☐

13. ¿Alguna vez le ha dicho un doctor que usted tiene diabetes (azúcar alta en la sangre o en la orina)?

No 0 ☐ → GO TO QUESTION 14
Sí 1 ☐

13a. ¿A qué edad le dijeron esto por primera vez?

☐☐ Edad en años

13b.PARA MUJERES: ¿Fue esto durante el embarazo solamente?

No 0 ☐
Sí 1 ☐

13c. ¿Está usando insulina?

No 0 ☐ → GO TO QUESTION 14
Sí 1 ☐

13d. ¿Fue insulina la primera medicina que usó para la diabetes?

No 0 ☐
Sí 1 ☐

ID NUMBER:									FORM CODE: MQS VERSION: A 09/01/10	Contact Occasion			SEQ #			

14. ¿Alguna vez le ha dicho un doctor que usted tiene un problema para dormir o problemas del sueño?

No	0	☐	→ END QUESTIONNAIRE
Sí	1	☐	
No sabe	9	☐	→ END QUESTIONNAIRE

15. ¿Qué problemas del sueño le dijo que tiene?

	No	Sí	
a. Insomnio	0☐	1☐	
b. Síndrome de piernas inquietas	0☐	1☐	
c. Narcolepsia	0☐	1☐	
d. Apnea	0☐	1☐	→ IF RESPONSE TO Q15d IS “YES”, ASK Q15d.1.
e. Otro	0☐	1☐	

Si otro, por favor especifique: _____

15d.1. ¿Alguna vez le han recetado usar una máquina (CPAP o BiPAP, por sus siglas en ingles) o algún dispositivo (aparato) para el tratamiento de la apnea del sueño?

No	0	☐
Sí	1	☐

Sueño – Sleep Habits in HCHS/SOL

Medical History (MQE/MQS) Question by Question Instructions

General Instructions

This section of the interview asks questions about personal medical history. The overall layout of this form starts with a determination of doctor-diagnosed medical conditions. Age of onset is determined for select conditions.

Question by Question Instructions

Q1 Question assesses participant history of doctor-diagnosed high blood pressure or hypertension. Occasionally, participants will indicate that their doctor told them they have "pre-hypertension". This should be coded as "no". Women who answer, "yes" to this question are administered a follow-up question, "Was this during pregnancy only" (Q1a). This question is asked because hypertension seen only during pregnancy is considered a different condition compared to women diagnosed with hypertension when not pregnant.

Q2 Questions assess personal history of angina. Angina pectoris or angina is caused by insufficient blood flow reaching part of the heart usually due to a narrowing of a coronary artery. Chest pain is a hallmark symptom of persons with angina. However, not all persons who experience chest pain have this condition. Therefore, it is important to check the yes box on this set of questions only if they can state that a doctor told them they had angina.

Q3 Questions assess personal history of heart attack. A heart attack is where a portion of the heart muscle has died from inadequate blood flow. The clinical name for heart attack is myocardial infarction.

Q4 Questions assess personal history of doctor diagnosed heart failure. Another clinical name for this condition is congestive heart failure or congestive cardiac failure. This diagnosis covers a variety of conditions in which the heart is unable to pump a sufficient amount of blood through the body. Heart failure should not be confused with heart attack or myocardial infarction.

Q5 Question designed to capture other types of heart problems not asked about in Q1-4. If the participant indicates yes, you are provided space to record the name of the condition.

Q6 Question assesses personal history of undergoing several cardiac procedures called a balloon angioplasty (or stent) and/or bypass surgery. Both procedures are designed to restore blood flow through coronary arteries which provide critical oxygen to the heart. A balloon angioplasty involves running a catheter from an artery in the thigh to the blocked coronary artery located on the outside wall of the heart. A small balloon attached to the catheter is then inflated to open up the passageway. Sometimes a "stent" is left to help maintain the opening.
A coronary artery bypass is sometimes referred to by its acronym "CABG" (pronounced 'cabbage'). This procedure uses healthy arteries harvested from other parts of the body which are

then used to ‘bypass’ damaged arteries supplying blood to the heart. The terms double and triple bypass mean that 2 and 3 arteries supplying blood to the heart have been surgically bypassed. You should check the ‘yes’ box on Q9 if the participant has had either an angioplasty or a bypass or both.

Q7 Question assesses personal history of doctor diagnosed stroke. An alternate clinical name for this condition is cerebrovascular accident (CVA). There are two major forms of stroke: 1) a thrombosis or embolism is when an artery which supplies oxygen to the brain is blocked, and 2) a hemorrhage is when one of these brain arteries bursts or leaks. Both forms of stroke can cause permanent damage to the brain. Stroke should not be confused with transient ischemic stroke, which is described below.

Q8 Question assesses personal history of doctor-diagnosed mini-stroke or transient ischemic attack (TIA). These mini-strokes can cause stroke-like symptoms caused by temporary blockages in the arteries supplying blood to the brain (confusion, numbness, weakness on one side of the body, etc). The short duration of symptoms is the main difference between TIA and stroke, which is assessed in Q7. Short duration is defined as less than 24 hours.

Q9 Question assesses personal history of balloon angioplasty or other surgery on the arteries of the neck to prevent a stroke. Balloon angioplasty (with or without a stent) can be used to clear blocked or partially blocked arteries in the neck which supply blood to the brain. A carotid endarterectomy can also be performed, in which the arteries in the neck are surgically opened and cleaned.

Q10 Question assesses personal history of abdominal aortic aneurysm (AAA) or ballooning of the aorta. The aorta is the largest artery in the body and is attached to the heart. All blood which has been replenished with oxygen by the heart passes through the aorta as it travels to other parts of the body. The ballooning of the aorta is caused by a weakness in the wall of this artery. Rupture of an AAA or weakened aneurysm can cause death.

Q11 Question assesses personal history of peripheral arterial disease (PAD) or blocked arteries of the legs. This condition is sometimes referred to as peripheral vascular disease (PVD). This condition is caused by partial blockages of the large arteries which supply blood to the lower extremities. It can cause pain when walking and in its more severe forms, pain while at rest, loss of sensation in the legs, and the need to amputate one or both legs due to gangrene (decay of tissue). If the participant indicates in Q11 that they had have PAD/PVD then you administer Q12, which inquires about treatment for this condition.

Q12 Question inquiries about the treatment for peripheral arterial disease. This question is only to be asked if participant responds “Yes” to Q11.

Q13 Questions assess personal history and age at onset of diabetes. Diabetes mellitus is a group of diseases in which the body cannot produce or effectively use insulin, a hormone which is used by the body to process sugars and other foods as energy for the body. This inability to process sugars and other energy sources can lead to chronically high levels of glucose circulating through the body. Some participants may indicate that a doctor has told them that they have “pre-

diabetes". These individuals do not meet the strict definition of diabetes and should be coded "no" on Q13.

Participants answering yes to Q13 are then administered Q13a-13d. These questions will be used to further classify those with diabetes (e.g., insulin-dependent diabetes). Q13a asks participant to estimate his/her age at diagnosis of diabetes. A code of "= =" is used when the participant states that the age of onset is "unknown".

Q13b should only be administered to women since it asks about diabetes during pregnancy (called gestational diabetes).

Q13c asks if they are being treated with insulin (which can be injected or administered by a pump). Those responding yes to this question are asked in Q13d if insulin was the first type of medicine used to treat their diabetes.

Q14 Question assesses personal history of doctor-diagnosed sleep disorders. If the participant is unsure of what you mean by sleep disorders, you can give examples such as insomnia and restless legs syndrome. Those responding "no or don't know" to this question or are not administered Q15 and 15d.1 and the questionnaire is finished. Those who respond "yes" to this question are then asked which sleep disorder they have.

Q15 Read each listed sleep disorder to the participant and check the box if they have the condition. Check all conditions that apply. Insomnia is the inability to sleep and/or the ability to remain asleep. Restless leg syndrome is characterized by the urge to move limbs in order to reduce uncomfortable sensations. Excessive daytime sleepiness is the primary symptom of narcolepsy. Sleep apnea is present when there are long pauses in breathing during sleep (e.g., 10 or more seconds between breaths) which cause lowered circulating oxygen levels in the bloodstream. Q15e is used to record any doctor-diagnosed sleep disorder not listed above. Check the box and write in the name of the disorder.

Interviewer can also use the following text in Spanish to explain sleep disorders:
a. Insomnio - es la incapacidad para dormir y / o la capacidad de permanecer dormido
b. Síndrome de piernas inquietas – cuando siente un deseo profundo de mover las piernas mientras está durmiendo o reposando
c. Narcolepsia – cuando se queda dormido(a) de repente, especialmente durante el día
d. Apnea – que deja de respirar mientras duerme

Q15d.1 This question is only asked if the participant responds "Yes" to Q15d, apnea. Assess whether the participant has been prescribed a CPAP or BIPAP machine to treat their sleep apnea. A continuous positive airway pressure (CPAP) device uses a small compressor to pump a controlled stream of air through a mask worn while sleeping. A bilevel positive airway pressure (BIPAP) device works in a similar fashion except that it provides differing air pressure level during breathing in as compared to when breathing out.

Sleep Attitudes
HCHS/SOL Sleep Ancillary Study

ID NUMBER:								

FORM CODE: SSE
VERSION: A 06/22/10

Contact Occasion ☐☐ SEQ # ☐☐

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.

Sleep Attitudes

How much do you agree with each of the following statements?

	Completely agree	Mostly agree	Mostly disagree	Completely disagree
1. Snoring during sleep is normal.	1 ☐	2 ☐	3 ☐	4 ☐
2. If you did not sleep enough one night, you can make it up the next night.	1 ☐	2 ☐	3 ☐	4 ☐
3. Regular exercise is good for sleep.	1 ☐	2 ☐	3 ☐	4 ☐
4. A hot bath before bed helps with sleep.	1 ☐	2 ☐	3 ☐	4 ☐
5. A light snack before bed helps with sleep.	1 ☐	2 ☐	3 ☐	4 ☐
6. Leaving some time to unwind before bed helps with sleep.	1 ☐	2 ☐	3 ☐	4 ☐
7. Watching TV or listening to the radio while in bed is recommended for sleeping.	1 ☐	2 ☐	3 ☐	4 ☐
8. It is normal to fall asleep in class or church if the speaker is boring and long winded.	1 ☐	2 ☐	3 ☐	4 ☐
9. It is normal to feel very sleepy in the mid-afternoon.	1 ☐	2 ☐	3 ☐	4 ☐
10. If you do not get enough sleep, it can affect performance at work.	1 ☐	2 ☐	3 ☐	4 ☐
11. If you do not get enough sleep, it can result in higher risk of accidents.	1 ☐	2 ☐	3 ☐	4 ☐
12. If you do not get enough sleep, it can lead to health problems.	1 ☐	2 ☐	3 ☐	4 ☐

ID NUMBER:									FORM CODE: SSE VERSION: A 06/22/10	Contact Occasion			SEQ #			

	Completely agree	Mostly agree	Mostly disagree	Completely disagree
13. If you do not get enough sleep, it can make it difficult to get along with others.	1 ☐	2 ☐	3 ☐	4 ☐
14. A regular sleep schedule is important for getting good sleep.	1 ☐	2 ☐	3 ☐	4 ☐
15. Sleeping during the night is better than sleeping during the day.	1 ☐	2 ☐	3 ☐	4 ☐
16. Getting enough sleep each night is important for overall health.	1 ☐	2 ☐	3 ☐	4 ☐
17. Eight hours of sleep per night are needed to be fully rested.	1 ☐	2 ☐	3 ☐	4 ☐
18. Daytime naps or siestas are good for your health.	1 ☐	2 ☐	3 ☐	4 ☐
19. As you get older, you do not need as much sleep to feel rested.	1 ☐	2 ☐	3 ☐	4 ☐
20. Sleeping is a pleasurable activity.	1 ☐	2 ☐	3 ☐	4 ☐

Sleep Attitudes_Spanish
HCHS/SOL Sleep Ancillary Study

ID NUMBER:								

FORM CODE: SSS
VERSION: A 08/30/10

Contact Occasion [ ][ ]

SEQ # [ ][ ]

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.

Sleep Attitudes

¿Qué tan de acuerdo está usted con las siguientes frases?

	Completamente de acuerdo	Mayormente de acuerdo	Mayormente no estoy de acuerdo	Completamente no estoy de acuerdo
1. El roncar cuando dormimos es normal.	1 ☐	2 ☐	3 ☐	4 ☐
2. Si usted no durmió lo suficiente una noche lo puede recuperar la próxima noche.	1 ☐	2 ☐	3 ☐	4 ☐
3. El ejercicio en forma regular es bueno para el sueño.	1 ☐	2 ☐	3 ☐	4 ☐
4. Un baño caliente antes de ir a la cama ayuda a dormir.	1 ☐	2 ☐	3 ☐	4 ☐
5. Un bocadillo antes de ir a la cama ayuda a dormir.	1 ☐	2 ☐	3 ☐	4 ☐
6. Tomar tiempo para relajarse antes de ir a cama ayuda a dormir.	1 ☐	2 ☐	3 ☐	4 ☐
7. Ver televisión o escuchar la radio cuando está en la cama es recomendable para dormir.	1 ☐	2 ☐	3 ☐	4 ☐
8. Es normal que le dé sueño cuando está en la clase o en la iglesia si el orador es aburrido y el tema es largo.	1 ☐	2 ☐	3 ☐	4 ☐
9. Es normal que le dé sueño después del medio día.	1 ☐	2 ☐	3 ☐	4 ☐
10. Si usted no duerme lo suficiente le puede afectar el desempeño de su trabajo.	1 ☐	2 ☐	3 ☐	4 ☐

ID NUMBER:									FORM CODE: SSS VERSION: A 08/30/10	Contact Occasion			SEQ #			

	Completamente de acuerdo	Mayormente de acuerdo	Mayormente no estoy de acuerdo	Completamente no estoy de acuerdo
11. Si usted no duerme lo suficiente puede resultar en un riesgo más alto de accidentes.	1 ☐	2 ☐	3 ☐	4 ☐
12. Si usted no duerme lo suficiente puede resultar en problemas de salud.	1 ☐	2 ☐	3 ☐	4 ☐
13. Si usted no duerme lo suficiente puede hacer que no se lleve bien con los demás.	1 ☐	2 ☐	3 ☐	4 ☐
14. El tener un horario fijo para dormir es importante para la buena salud.	1 ☐	2 ☐	3 ☐	4 ☐
15. El dormir durante la noche es mejor que dormir durante el día.	1 ☐	2 ☐	3 ☐	4 ☐
16. El dormir lo suficiente todas las noches es importante para la salud.	1 ☐	2 ☐	3 ☐	4 ☐
17. Se necesitan ocho horas de dormir cada noche para estar bien descansado.	1 ☐	2 ☐	3 ☐	4 ☐
18. El dormitar durante el día o tomarse una siesta es bueno para la salud.	1 ☐	2 ☐	3 ☐	4 ☐
19. A medida que envejecemos, no necesitamos dormir tanto tiempo para sentirnos descansados.	1 ☐	2 ☐	3 ☐	4 ☐
20. El dormir es un acto placentero.	1 ☐	2 ☐	3 ☐	4 ☐

Sueño – Sleep Habits in HCHS/SOL

Sleep Attitudes (SSE/SSS) Question by Question Instructions

General Instructions:

The Sleep Attitudes Questionnaire is a 20-item measure created to assess participant perception of the importance of sleep and ideas about sleep hygiene. Views about various aspects of sleep (sleep hygiene, implications of poor sleep, outcomes, etc.) are addressed. Point out to participants that all 20 items on this instrument will have the same four response categories, which are: completely agree, mostly agree, mostly disagree, and completely disagree. Note that all the questions must be read to the participant and that the answer choices should still be repeated after each question.

Q1-Q20: Read the script exactly as it appears. You may re-read the answer options if the participant requests. When asking these questions, be careful to not comment on respondent's answers and to record answers in a non-judgmental manner. If you are asked about the meaning of specific questions, you should encourage participants to interpret questions in the way that makes the most sense to them. It is critical that you do not provide definitions or interpretations of these questions.

Work Schedule Questionnaire

ID NUMBER: ☐☐☐☐☐☐☐☐ FORM CODE: WSE VERSION: A 09/13/10 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.

A. Current Employment Status

1. Are you currently employed?
   - No 0 ☐ → GO TO QUESTION 2
   - Yes 1 ☐ → GO TO QUESTION 3

2. Are you either of the following:

	No	Yes	
a. Homemaker (i.e. care for family home)	0 ☐	1 ☐	→ END QUESTIONNAIRE
b. Student	0 ☐	1 ☐	→ END QUESTIONNAIRE
c. Retired/Disabled	0 ☐	1 ☐	→ END QUESTIONNAIRE
d. Unemployed/Seeking Work	0 ☐	1 ☐	→ END QUESTIONNAIRE

3. In a typical week, how many hours do you work per week? *Please include time worked in all jobs you may have.*

   ☐☐☐ Hours

4. How many jobs do you have?
   - One 1 ☐
   - Two 2 ☐
   - Three 3 ☐
   - More than three 4 ☐

5. How many months in a year did you work in the past year?

   ☐☐ Months

6. In a typical week, how many days do you go to work per week?

   ☐ Number of days per week

7. On a typical day, do you have a regular work schedule?
   - No 0 ☐ → GO TO QUESTION 10
   - Yes 1 ☐

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8. When do you usually begin work? ☐☐:☐☐ __ __ am/pm

9. When do you usually end work? ☐☐:☐☐ __ __ am/pm

10. How many days per month do you work extra hours beyond your usual schedule?
☐☐ Days per month

11. Which of the following best describes your usual work schedule? (*Mark only one*)
- Day shift 1 ☐
- Afternoon shift 2 ☐
- Night Shift 3 ☐
- Split Shift 4 ☐
- Irregular shift/on call 5 ☐
- Rotating shift 6 ☐

12. At your current job(s), do you ever work the late night shift (after midnight)?
- No 0 ☐ → GO TO QUESTION 14
- Yes 1 ☐

13. Do you work the late night shift (after midnight)…?
- Usually (at least 3 days per week) 1 ☐
- Sometimes (at least 1 day per week) 2 ☐
- Rarely (less than 1 day per week) 3 ☐
- On a rotating schedule 4 ☐ (*Please specify*): _____

14. At your current job(s), do you ever work the early morning shift (start work before 6am)?
- No 0 ☐→ GO TO QUESTION 16
- Yes 1 ☐

15. Do you work the early morning shift (start work before 6am)…?
- Usually (at least 3 days per week) 1 ☐
- Sometimes (at least 1 day per week) 2 ☐
- Rarely (less than 1 day per week) 3 ☐
- On a rotating schedule 4 ☐ (*Please specify*): _____

16. On average, how long does it take for you to travel from home to work each day?
☐ Hours ☐☐ Minutes

17. On average, how long does it take for you to travel from work to home each day?
☐ Hours ☐☐ Minutes

Work Schedule Questionnaire_Spanish
HCHS/SOL Sleep Ancillary Study

ID NUMBER: ☐☐☐☐☐☐☐☐ FORM CODE: WSS VERSION: A 09/13/10 Contact Occasion ☐☐ SEQ # ☐☐

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.

A. Current Employment Status

1. ¿Trabaja actualmente?
   - No 0 ☐ → GO TO QUESTION 2
   - Sí 1 ☐ → GO TO QUESTION 3

2. ¿Es usted…?

	No	Sí	
a. Ama de casa (por ejemplo, cuida el hogar de la familia)	0 ☐	1 ☐	→ END QUESTIONNAIRE
b. Estudiante	0 ☐	1 ☐	→ END QUESTIONNAIRE
c. Retirado/Incapacitado	0 ☐	1 ☐	→ END QUESTIONNAIRE
d. Desempleado/Buscando Empleo	0 ☐	1 ☐	→ END QUESTIONNAIRE

3. En una semana típica, ¿Cuántas horas trabaja en su(s) empleo(s)?
   ☐☐☐ Horas

4. ¿Cuántos trabajos tiene?
   - Uno 1 ☐
   - Dos 2 ☐
   - Tres 3 ☐
   - Más de tres 4 ☐

5. ¿Cuántos meses del año trabajó usted durante el último año?
   ☐☐ Meses

6. En una semana típica, ¿cuántos días a la semana va usted a trabajar?
   ☐ Número de días a la semana

7. En un día típico, ¿tiene usted un horario de trabajar regular?
   - No 0 ☐ → GO TO QUESTION 10
   - Sí 1 ☐

8. ¿A qué hora comienza usted a trabajar normalmente? ☐☐:☐☐ __ __ am/pm

9. ¿A qué hora termina usted de trabajar normalmente? ☐☐:☐☐ __ __ am/pm

10. ¿Cuántos días al mes trabaja usted horas adicionales además de su horario normal de trabajo?

☐☐ Días al mes

11. ¿Cuál de los siguientes turnos describe mejor su horario normal de trabajo? (*Mark only one*)

Turno de la mañana	1	☐
Turno de la tarde	2	☐
Turno de la noche	3	☐
Turno dividido en dos	4	☐
Turno irregular/ estar disponible cuando se le necesite	5	☐
Turnos rotativos	6	☐

12. En su trabajo actual, ¿alguna vez trabaja tarde durante el turno de la noche (después de la medianoche)?

No 0 ☐ → GO TO QUESTION 14
Sí 1 ☐

13. ¿Trabaja usted en el turno de la noche (después de la medianoche)…?

Usualmente (al menos 3 días a la semana)	1	☐
A veces (al menos 1 día a la semana)	2	☐
Raramente (menos de 1 día a la semana)	3	☐
Rotativamente	4	☐ (*Por favor, especifique*): _____

14. ¿Trabaja usted en el turno de la mañana (antes de las 6 AM)?

No 0 ☐→ GO TO QUESTION 16
Sí 1 ☐

15. ¿Trabaja usted en el turno de la mañana (antes de las 6AM)…?

Usualmente (al menos 3 días a la semana)	1	☐
A veces (al menos 1 día a la semana)	2	☐
Raramente (menos de 1 día a la semana)	3	☐
Rotativamente	4	☐ (*Por favor, especifique*): _____

16. En un día típico, ¿cuánto tiempo le toma viajar de la casa al trabajo?

☐ Horas ☐☐ Minutos

17. En un día típico, ¿cuánto tiempo le toma viajar del trabajo a la casa?

☐ Horas ☐☐ Minutos

Sueño – Sleep Habits in HCHS/SOL

Work Schedule (WSE/WSS) Question by Question Instructions

General Instructions:
The questions on occupation are designed to learn about the participants' current work schedule and commute. Keep in mind that participants may have more than one job.

Question by Question Instructions:

Q1 This initial question will guide the administration of the questionnaire by classifying participants as currently working or not. Any person who is earning some income in return for the services or work they provide is considered employed. Participants who have retired from one job but are continuing to work at another job or who re-entered the labor force after retirement should answer 'yes' to this question. Students and homemakers should answer 'no' to this question. If a subjects answers 'no' on Q1, continue to Q2. If a subject answers 'yes' to Q1, skip to Q3.

Q2 Participants may need some clarification regarding what a homemaker is and how to define a student. If the participant requests clarification, the following definitions may be used:
a. HOMEMAKER Any person whose primary responsibility is caring for the children in their family and taking care of the home environment (*Alma de la casa*). This could also be a person whose primary responsibility is taking care of an ill person or elderly person at home. A person who is unemployed and looking for work is not considered a homemaker.
b. STUDENT Any person attending a community college, technical school, or university either part-time or full-time.
c. RETIRED/DISABLED Any person that has left the workforce due to retirement or because they are not able to work due to a disability. These people may be getting assistance from the government, but they are not currently working.
d. UNEMPLOYED/SEEKING WORK Any person not currently employed. These people may be receiving unemployment benefits or government assistance, but are not currently employed.
Despite the answer to Q2, if the person is unemployed the questionnaire should be ended after Q2.

Q3 A typical week can be understood as an average, common, or standard week. The participant should consider ALL of their jobs when determining their total hours worked per week. IMPORTANT: the Spanish translation of this question was changed to "En una semana típica,¿Cuántas horas trabaja en su(s) empleo(s)?" Please consider this when viewing earlier versions of this form.

Q4 This question asks how many jobs a participant currently has. Include both part-time and full-time jobs.

Q5 This is a standard question used to determine if a participant faces seasonal unemployment, which occurs often in the US.

Q6 A typical week can be understood as an average, common, or standard week. Participants should provide an average or estimate of the number of days worked. This will allow researchers to understand if participants' work, part-time, full time, or more than that. As with question 5, the interviewer will need to prompt the participant to consider ALL the participant's jobs when answering this question.

Q7 This question is intended to help researchers understand a number of issues related to sleep and health. A regular work schedule has predictable times and hours with little variation.

The question is used to begin a skip pattern that helps to identify those that do shift work and/or perform overtime work.

Q8 Participants should be directed to note the EARLIEST time that they start work ON A TYPICAL DAY.

Q9 Participants should be directed to note the LATEST time that they end work ON A TYPICAL DAY.

Q10 The goal of this question is to determine if the participant works overtime all the time or only occasionally.

Q11 This question should refer to the participant's PRIMARY job identified in Q3. Many people work in shifts. The precise definitions of each shift may vary by an employer. However, if the participant needs clarification on the meaning or hours typically associated with each of these shifts, the following definitions can be provided with the understanding that the times may vary by 1-2 hours:

DAY SHIFT: The day shift will typically be between 6am-2pm or 9am-5pm.

AFTERNOON SHIFT: The afternoon shift will typically be 2pm-10pm or 3pm-11pm

NIGHT SHIFT: The night shift will typically be 10pm-6am or 11pm-7am

SPLIT SHIFT: A person with a split shift works twice over a day with 2 or more hours between work periods. For example, they might regularly work both four hours in the day and four hours in night shift on some days.

IRREGULAR SHIFT OR ON-CALL: A person with an irregular shift is one who works when called and never knows his/her shift for certain.

ROTATING SHIFT: A rotating shift means that you work one type of shift sometimes and another at other times. However, this is systematic. You know which shift you will work on each day.

Q12 It is important to learn if the person has EVER worked after midnight in any of their current jobs. They might work a different shift now but in the past, they did work at night. Or if they work the night shift now then this answer will automatically be coded 'yes.'

Q13 Because working at night is felt to be particularly difficult, we are interested in continuing to probe this topic. This question asks if the night work noted in Q12 is on a regular basis or if it only occurs occasionally or on a rotating basis.

Q14 It is important to learn if the person has EVER worked in the early morning (before 6am) in any of their current jobs. They might work a different shift now but in the past, they worked in the early morning.

Q15 We are interested in continuing to probe this topic. This question asks if the early morning work noted in Q14 is on a regular basis or if it only occurs occasionally or on a rotating basis

Q16 Commute time may be an important factor that limits sleep duration. In this question, the amount of time that it takes someone to get from home to their first job of the day (whether they take public transportation, carpool, drive themselves, walk, etc.) is assessed. If a person regularly runs errands during their commute (such as dropping children off at a child care provider), please include this time in the response.

Q17 Since commute times to and from work may be different, a second question is asked to determine the time it takes for the participant to travel home after their last job.

Sleep Questionnaire
HCHS/SOL Sleep Ancillary Study

ID NUMBER:								

FORM CODE: SPE
VERSION: A 08/16/10

Contact Occasion [ ][ ] SEQ # [ ][ ]

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	☐

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 times 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 ☐

Sleep Questionnaire_Spanish
HCHS/SOL Sleep Ancillary Study

ID NUMBER:									FORM CODE: SPS VERSION: A 09/01/10	Contact Occasion			SEQ #		

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.

Las siguientes dos preguntas se refieren a la hora que va a la cama a dormir y la hora que se levanta de la cama al despertarse (no incluye las siestas).

1. ¿A qué hora se va a dormir generalmente?

   a. Durante los días de semana ☐☐:☐☐ __ __ am/pm

   b. Durante los fines de semana ☐☐:☐☐ __ __ am/pm

2. ¿A qué hora se despierta generalmente?

   a. Durante los días de semana ☐☐:☐☐ __ __ am/pm

   b. Durante los fines de semana ☐☐:☐☐ __ __ am/pm

3. Durante una semana normal, ¿cuántas veces toma usted una siesta de 5 minutos o más?

Ninguna	0 ☐
1 o 2 veces	1 ☐
3 o 4 veces	2 ☐
5 veces o más	3 ☐

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Las siguientes preguntas tratan de sus hábitos de dormir. Por favor, escoja una respuesta para cada pregunta. Escoja la respuesta que mejor describe con qué frecuencia se ha encontrado en cada situación durante las últimas *4 semanas.*

	No, no en las últimas 4 semanas	Sí, menos de una vez por semana	Sí. 1ó 2 veces por semana	Si, 3 ó 4 veces por semana	Si, 5 ó más veces por semana
4. ¿Tuvo problemas para quedarse dormido(a)?	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
5. ¿Se despertó varias veces durante la noche?	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
6. ¿Se despertó más temprano de lo que había planeado?	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
7. ¿Tuvo problemas para quedarse dormido(a) nuevamente después de que se despertó más temprano de lo acostumbrado?	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
8. ¿Toma pastillas para ayudarse a dormir?	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
9. ¿Tuvo problemas para dormir que lo(a) hacían sentirse irritable?	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
10. ¿Se sintió con mucho sueño durante el día?	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐

11. En general, ¿cómo ha dormido durante las noches normales en las últimas 4 semanas?

Muy profundo o muy descansado(a) 0 ☐
Profundo o descansado(a) 1 ☐
Más o menos bien 2 ☐
Intranquilo(a) 3 ☐
Muy intranquilo(a) 4 ☐

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12. ¿Qué probabilidad hay de que usted se adormezca o se quede dormido(a) (no sólo "sentirse cansado(a)") en cada una de las siguientes situaciones? Si usted nunca se encuentra en tal situación o se encuentra en esa situación rara vez, por favor, dénos la respuesta que a su parecer, se parece mejor a lo que sucedería. Seleccione una opción para cada frase.

	Ninguna probabilidad	Poca probabilidad	Probabilidad moderada	Mucha probabilidad
a. Sentado(a) y leyendo	1 ☐	2 ☐	3 ☐	4 ☐
b. Viendo televisión	1 ☐	2 ☐	3 ☐	4 ☐
c. Sentado(a) y estando inactivo(a) en un lugar público (tal como en un teatro o en una reunión)	1 ☐	2 ☐	3 ☐	4 ☐
d. Ir como pasajero(a) en un automóvil durante una hora sin tomar un descanso	1 ☐	2 ☐	3 ☐	4 ☐
e. Recostarse a descansar en la tarde cuando las circunstancias lo permiten	1 ☐	2 ☐	3 ☐	4 ☐
f. Sentado(a) y hablando con alguien	1 ☐	2 ☐	3 ☐	4 ☐
g. Sentado(a) tranquilamente después de almorzar, sin haber tomado alcohol	1 ☐	2 ☐	3 ☐	4 ☐
h. En un automóvil, cuando se detiene por unos pocos minutos en el tráfico	1 ☐	2 ☐	3 ☐	4 ☐
i. En la mesa a la hora de cenar	1 ☐	2 ☐	3 ☐	4 ☐
j. Mientras maneja	1 ☐	2 ☐	3 ☐	4 ☐

13. ¿Con qué frecuencia ronca actualmente? *(Mark only one)*

Nunca 1 ☐
Rara vez (1a 2 noches por semana) 2 ☐
Algunas veces (3 a 5 noches por semana) 3 ☐
Siempre o casi siempre (6 a 7 noches por semana) 4 ☐
No sabe 9 ☐

14. ¿Con qué frecuencia tiene usted momentos cuando deja de respirar mientras duerme?

Nunca 1 ☐
Rara vez (1 a 2 noches por semana) 2 ☐
Algunas veces (3 a 5 noches por semana) 3 ☐
Siempre o casi siempre (6 a 7 noches por semana) 4 ☐
No sabe 9 ☐

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15. ¿Alguna vez ha sentido el deseo de mover sus piernas debido a la incomodidad o por sensaciones desagradables en sus piernas?

No	0 ☐	→ **END QUESTIONNAIRE**
Sí	1 ☐	
No sabe	9 ☐	→ **END QUESTIONNAIRE**

16. ¿Siente alguna vez la necesidad de moverse para aliviar la incomodidad, como por ejemplo caminar, o de aliviar la incomodidad frotando sus piernas?

No	0 ☐
Sí	1 ☐
No sabe	9 ☐

17. ¿Son estos síntomas peores cuando está descansando, pero con algún alivio temporal al realizar alguna actividad?

No	0 ☐
Sí	1 ☐
No sabe	9 ☐

18. ¿Son estos síntomas peores mas tarde en el día o durante la noche?

No	0 ☐
Sí	1 ☐
No sabe	9 ☐

Sueño – Sleep Habits in HCHS/SOL

Sleep Form (SPE/SPS) Question by Question Instructions

General Instructions:
This section of the interview asks about sleep patterns and symptoms of sleep disturbances.

Question by Question Instructions:

Q1-2. Ask the participant what (clock) times they usually go to bed in order to sleep. The participant should provide the times relative to their usual longest period in bed (i.e., not including naps). To clarify, ask participant to report bed and wake times that are most usual for them on their average weekday and weekend. If participant works or goes to school for most of the year, ask them to report the times they would go to bed and wake when following this schedule. If they are a shift worker, they should provide the most frequent times they go to sleep for a period that includes their longest sleep period (e.g., if working the night shift, this may be 7 AM to 2 PM). The clock times should reflect times from "lights off" to arising from bed. For example, if they read in bed, or watch TV in bed before sleep, they should report the times they turn off the light and close their eyes in an attempt to sleep. If they lay in bed awake in the morning, they should report the times they actually get out of bed. Part A refers to their schedule on weekdays and Part B for weekends. Sleep schedules may vary during vacation times compared to work or school times. If so, they should report usual weekend and weekday times for the times of the year when working or going to school versus other days, unless they only work or go to school for a minority of the year. Check to make sure that the times for awakening occur after the times reported for falling asleep. Use a 12 hour clock time frame, and also check that AM and PM are checked appropriately. Provide information to the nearest minute.

Q3. A nap is defined as any period of sleep lasting at least 5 minutes aside from the major sleep period. Ask how often they nap for 5 or more minutes during a usual week. Include all naps whether they are voluntary (planned) or involuntary (unplanned). It does not matter if they nap in their usual sleep quarters or elsewhere, or fall asleep in a chair or bed.

Q4-10. Ask the participant to estimate how often they have experienced each of the identified symptoms over the prior 4 weeks. Interviewer should place emphasis on 4 weeks. If symptoms have varied over this period, the participant should estimate how often the symptom has occurred on average over this time.

Q4 refers to difficulty getting to sleep after turning off the lights for their longest sleep period.

Q5 refers to waking up 2 or more times during their longest sleeping period. These can be very short or long periods, and should be counted regardless of whether or not they got out of bed.

Q6 typically refers to early morning awakenings – waking up earlier than they intended or needed to, or earlier than the alarm clock was set with regards to the major sleep period.

Q7 refers to problems getting back to sleep if waking up too early. If they answered 'no' to Q6, they should answer 'no' to Q7.

Q8 refers to any use of sleeping pills to help them sleep over the last 4 weeks. These may be prescription (e.g., Ambien) or non-prescription medications, such as anti-histamines, including herbal remedies that come in pill form.
Q9 refers to their assessment of whether sleep problems made them feel grumpy – this could be based on self impression or what others have told them.
Q10 refers to their self perception of feeling overly sleepy during the day. They do not need to report actual instances of falling asleep. Some people have trouble distinguishing tiredness or fatigue from sleepiness. Here, sleepiness refers to trouble staying awake and alert—not just tired.

Q11. Ask the participant to rate the quality of his usual night's sleep. Average quality refers to something midway between very sound to very restless—not perceived to be particularly restful or restless. It does not refer to what they think is the quality of the "average" person's sleep.

Q12. 12a-h. These questions make up the Epworth Sleepiness Scale, the most common assessment of daytime sleepiness. Ask the participant to rate his chance of dozing off (not just feeling tired) in each of the situations.
12a-j. If the person has never or only rarely engages in any given activity (e.g., driving), he should guess how likely he would fall asleep if he actually did that activity. 12c refers to activities where the participant may be sitting quietly in a public place, such as a movie theatre or a meeting hall or church, but does not refer to loud active places like a sports stadium. 12e. refers to situations where the participant can lay down and rest, whether it was a planned nap or not. 12h. refers to likelihood of dozing while driving a car and stopped for a few minutes in traffic or at a traffic light. 12i. refers to sitting at the dinner table for a meal. 12j. refers to any likelihood of dozing while driving a car.

Q13-14. Ask the participant to estimate his frequency of snoring (Q 13) (or stop breathing, Q 14) over a typical week (number of nights per week.) If the participant's usual sleep time is in the day (i.e, shift workers), he should estimate his sleeping frequency during his longest period of sleeping in the day. He can report these symptoms based on his own perceptions or based on what others have told him. He does not have to judge how loudly his snoring was to answer this question. If he only knows how often he snored or stopped breathing in the past (because there were people who witnessed his sleep in the past but not the present) he should answer the question based on the most recent information he is aware of. 'Stop breathing' may include breathing pauses followed by snorting sounds.

Q15. Ask the participant whether he ever experiences a need to move his legs because of uncomfortable feelings in his calves. This should not include feelings that his feet "fell asleep" or were "numb" but refer to more of an irritating, creeping, crawling sensation. If answering no, then do not ask Q16-17.

Q16. If answered yes to Q15, then ask (Q16) if this disagreeable feeling results in a need to move his legs with walking, or rub his legs, to relieve this sensation?

Q17. If answered yes to Q15, then ask the participant if these leg symptoms are usually worse when resting and feel at least temporarily better by moving the legs. If they report they are worse at rest but not better with movement, answer 'no' to Q 17.

Q18 Ask if these leg symptoms are worse later in the day or at night compared to earlier in the day. If participant asks for clarification, later in the day can be defined as 6 pm – midnight.

Neighborhood Stress
HCHS/SOL Sleep Ancillary Study

ID NUMBER: ☐☐☐☐☐☐☐☐ FORM CODE: NSE VERSION: A 08/10/10 Contact Occasion ☐☐ SEQ # ☐☐

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.

Neighborhood Stress

Things about people's neighborhoods may be important to their health. Now we would like to ask you some questions about what it is like to live in your neighborhood. By neighborhood we mean the area around where you live and around your house. It may include places you shop, religious or public institutions, or a local business district. It is the general area around your house where you might perform routine tasks, such as shopping, going to the park, or visiting with neighbors. Please take the time to answer carefully, but do not spend too much time on any one question. Remember that there are no right or wrong answers.

1. How many blocks are in the area that you think of as your neighborhood? ☐☐

2. How long have you lived in this neighborhood? (years OR months) ☐☐ : ☐☐ (Years or Months)

For each of the following statements, please tell me whether you agree by choosing the best option.

	Strongly Agree	Agree	Neither agree nor disagree	Disagree	Strongly Disagree
3. This is a close-knit neighborhood	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
4. People around here are willing to help their neighbors	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
5. People in this neighborhood generally don't get along with each other	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
6. People in this neighborhood can be trusted	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
7. People in this neighborhood do not share the same values	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐

ID NUMBER:									FORM CODE: NSE VERSION: A 08/10/10	Contact Occasion			SEQ #			

8. How safe from crime do you consider your neighborhood to be? Please rate on a scale from 1 to 5.

Very safe	1 ☐
	2 ☐
Safe	3 ☐
	4 ☐
Not at all safe	5 ☐

Think about your neighborhood as a whole, then please choose the response for each of the following to show how much of a problem each one is in your neighborhood.

	Very serious Problem	Somewhat serious problem	Minor problem	Not really a problem
9. Excessive noise	1 ☐	2 ☐	3 ☐	4 ☐
10. Heavy traffic or speeding cars	1 ☐	2 ☐	3 ☐	4 ☐
11. Lack of access to adequate food shopping	1 ☐	2 ☐	3 ☐	4 ☐
12. Lack of parks or playgrounds	1 ☐	2 ☐	3 ☐	4 ☐
13. Trash and litter	1 ☐	2 ☐	3 ☐	4 ☐
14. No sidewalks or poorly maintained sidewalks	1 ☐	2 ☐	3 ☐	4 ☐
15. Violence	1 ☐	2 ☐	3 ☐	4 ☐

Neighborhood Stress_Spanish
HCHS/SOL Sleep Ancillary Study

ID NUMBER:									FORM CODE: NSS VERSION: A 08/18/10	Contact Occasion			SEQ #		

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.

Neighborhood Stress

Los vecindarios (o barrios) donde vive la gente pueden ser importantes para la salud. Por ello nos gustaría hacerle unas preguntas sobre la vida en su vecindario. Por vecindario nos referimos a los alrededores de su casa, incluyendo por ejemplo los lugares donde hace las compras, instituciones públicas y religiosas, o un distrito de negocios local. Incluye los lugares donde hace cosas de la vida diaria, por ejemplo: donde compra, va al parque o visita a los vecinos. Tome el tiempo necesario para responder con exactitud, pero no pase demasiado tiempo en ninguna de las preguntas. Ninguna repuesta es más correcta que las demás.

1. ¿Cuántos bloques o manzanas tiene el área que usted considera su vecindario? ☐☐

2. ¿Cuánto tiempo ha vivido en este vecindario? (años y/o meses) ☐☐ : ☐☐ (Años y/o Meses)

Para cada una de las siguientes afirmaciones, díganos si está de acuerdo o no seleccionando la opción más apropiada.

	Totalmente de acuerdo	De acuerdo	Ni de acuerdo ni en desacuerdo	En desacuerdo	Totalmente en desacuerdo
3. En este vecindario la gente está muy unida	1☐	2☐	3☐	4☐	5☐
4. Las personas aquí están dispuestas a ayudar a los vecinos	1☐	2☐	3☐	4☐	5☐
5. Las personas de este vecindario en general no se llevan bien entre sí	1☐	2☐	3☐	4☐	5☐
6. Se puede confiar en las personas de este vecindario	1☐	2☐	3☐	4☐	5☐
7. Las personas en este vecindario no comparten los mismos valores	1☐	2☐	3☐	4☐	5☐

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8. En relación con la delincuencia, ¿es seguro su vecindario? Por favor evalúelo basado en una escala de 1 a 5:

Muy seguro	1 ☐
	2 ☐
Seguro	3 ☐
	4 ☐
Muy inseguro	5 ☐

Piense en su vecindario, luego indique la opción correspondiente si cada una de las situaciones que aparecen a continuación es un problema en su vecindario

	Problema muy grave	Problema grave	Problema menor	No es realmente un problema
9. Ruido excesivo	1 ☐	2 ☐	3 ☐	4 ☐
10. Mucho tráfico o automóviles que van muy rápido	1 ☐	2 ☐	3 ☐	4 ☐
11. No hay donde comprar buena comida	1 ☐	2 ☐	3 ☐	4 ☐
12. Falta de parques o lugares para jugar o hacer deportes	1 ☐	2 ☐	3 ☐	4 ☐
13. Basura y desperdicios	1 ☐	2 ☐	3 ☐	4 ☐
14. Falta de aceras o aceras en mal estado	1 ☐	2 ☐	3 ☐	4 ☐
15. Violencia	1 ☐	2 ☐	3 ☐	4 ☐

Sueño – Sleep Habits in HCHS/SOL

Neighborhood Stress (NSE/NSS) Question by Question Instructions

The neighborhood stress scale is a measure of stress associated with the conditions in one's external living environment. These items assess such factors as neighborhood support, safety, cleanliness, noise level, and accessibility to resources. Note that this measure has items with very different response options and multiple parts.

Read the script exactly as it appears. Carefully and slowly read the description of what 'neighborhood' refers to in the instructions. If they ask any questions about how they should define neighborhood, you should prompt participants to define neighborhood in whatever way is most meaningful to them. Proceed by asking each question and then reading each response category. You may re-read the answer options if the participant requests. When asking these questions, you should be careful to not comment on respondent's answers and to record answers in a non-judgmental manner.

Q1 Question asks about how many blocks the participant considers to be his or her neighborhood. Participant should define their neighborhood in whatever manner is most meaningful to him/her.
SPANISH: Se debe definir 'barrio' en cualquier manera que prefiere.

Q2 Participants are asked how long they have lived in their neighborhood in years <u>and</u> months. If the participant only states the answer in years, ask them if they can tell you months as well. For example, if the participant states that they lived in their neighborhood for five years, ask: *And how many months?*
SPANISH: ¿Cuántos meses?

Q3-Q7 Point out to participants that the next five statements will have the same five response categories, which are: strongly agree, agree, neither agree nor disagree, disagree, and strongly disagree. Then proceed to read each statement and each response option.

Q8 Ask participants to rate safety "on a scale of 1 to 5, with 1 being very safe, 3 safe, and 5 not at all safe". If asked clarify response item 2 as between safe and very safe and item 4 as between safe and not at all safe.

Q9-Q15 Point out to participants that the next seven statements will have the same four response categories, which are: very serious problem, somewhat serious problem, minor problem, and not really a problem. Then proceed to read each statement and each response option.

Sleep Questionnaire II
HCHS/SOL Sleep Ancillary Study

ID NUMBER:									FORM CODE: SQE VERSION: A 08/10/10	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.

Check the response for each item that best describes you during ***the past two weeks****.*

1. Considering only your own "feeling best" rhythm, at what time would you get up if you were entirely free to plan your day?
   - 5:00 – 6:30 am 1 ☐
   - 6:30 – 7:45 am 2 ☐
   - 7:45 – 9:45 am 3 ☐
   - 9:45 – 11:00 am 4 ☐
   - 11:00 am – 12:00 (noon) 5 ☐

2. During the first half hour after having woken in the morning, how tired do you feel?
   - Very tired 1 ☐
   - Fairly tired 2 ☐
   - Fairly refreshed 3 ☐
   - Very refreshed 4 ☐

3. At what time in the evening do you feel tired and, as a result, in need of sleep?
   - 8:00 – 9:00 pm 1 ☐
   - 9:00 – 10:15 pm 2 ☐
   - 10:15 pm – 12:45 am 3 ☐
   - 12:45 – 2:00 am 4 ☐
   - 2:00 – 3:00 am 5 ☐

4. At what time of the day do you think that you reach your "feeling best" peak?
   - 5:00 – 8:00 am 1 ☐
   - 8:00– 10:00 am 2 ☐
   - 10:00– 4:45 pm 3 ☐
   - 5:00 – 9:45 pm 4 ☐
   - 10:00– 4:45 am 5 ☐

5. One hears about "morning" and "evening" types of people. Which ONE of these types do you consider yourself to be?
   - Definitely a "morning" type. 1 ☐
   - Rather more a "morning" than an "evening" type 2 ☐
   - Rather more an "evening" than a "morning" type 3 ☐
   - Definitely an "evening" type 4 ☐

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Check the response for each item that best describes you during ***the past two weeks****.*

6. Please rate the current **SEVERITY** of your difficulty falling asleep.
   - None 0 ☐
   - Mild 1 ☐
   - Moderate 2 ☐
   - Severe 3 ☐
   - Very Severe 4 ☐

7. Please rate the current **SEVERITY** of your difficulty staying asleep.
   - None 0 ☐
   - Mild 1 ☐
   - Moderate 2 ☐
   - Severe 3 ☐
   - Very Severe 4 ☐

8. Please rate the current **SEVERITY** of your problem of waking up too early.
   - None 0 ☐
   - Mild 1 ☐
   - Moderate 2 ☐
   - Severe 3 ☐
   - Very Severe 4 ☐

9. How **SATISFIED**/dissatisfied are you with your current sleep pattern?
   - Very Satisfied 0 ☐
   - Satisfied 1 ☐
   - Neither Satisfied or Dissatisfied 2 ☐
   - Dissatisfied 3 ☐
   - Very Dissatisfied 4 ☐

10. In the past 2 weeks, have you had a problem with your sleep?
   - No 0 ☐ → GO TO QUESTION 14
   - Yes 1 ☐

11. To what extent do you consider your sleep problem to **INTERFERE** with your daily functioning (e.g. daytime fatigue, ability to function at work/ daily chores, concentration, memory, mood, etc.)?
   - Not at all interfering 0 ☐
   - A little 1 ☐
   - Somewhat 2 ☐
   - Much 3 ☐
   - Very much interfering 4 ☐

12. How **NOTICEABLE** to others do you think your sleeping problem is in terms of impairing the quality of your life?
   - Not at all noticeable 0 ☐
   - Barely 1 ☐
   - Somewhat 2 ☐
   - Much 3 ☐
   - Very much noticeable 4 ☐

ID NUMBER:									FORM CODE: SQE VERSION: A 08/10/10	Contact Occasion			SEQ #			

13. How **WORRIED**/distressed are you about your current sleep problem?
    - Not at all 0 ☐
    - A little 1 ☐
    - Somewhat 2 ☐
    - Much 3 ☐
    - Very much 4 ☐

14. Do you have a TV in your bedroom?
    - No 0 ☐ → GO TO QUESTION 16
    - Yes 1 ☐

For this section, please check the response for each item that best describes you during ***the past four weeks****.*

15. Do you ever use the TV to help you fall asleep?
    - No, not in the past 4 weeks 0 ☐
    - Yes, less than once a week 1 ☐
    - Yes, 1-2 times a week 2 ☐
    - Yes, 3-4 times a week 3 ☐
    - Yes, 5 or more times a week 4 ☐

16. Do you ever have a drink of alcohol to help you sleep?
    - No, not in the past 4 weeks 0 ☐
    - Yes, less than once a week 1 ☐
    - Yes, 1-2 times a week 2 ☐
    - Yes, 3-4 times a week 3 ☐
    - Yes, 5 or more times a week 4 ☐

17. Do you ever drink a non-alcoholic beverage like warm milk or herbal tea to help you sleep?
    - No, not in the past 4 weeks 0 ☐
    - Yes, less than once a week 1 ☐
    - Yes, 1-2 times a week 2 ☐
    - Yes, 3-4 times a week 3 ☐
    - Yes, 5 or more times a week 4 ☐

18. Do you ever use a natural or herbal medicine (like melatonin or valerian) to help you sleep?
    - No, not in the past 4 weeks 0 ☐
    - Yes, less than once a week 1 ☐
    - Yes, 1-2 times a week 2 ☐
    - Yes, 3-4 times a week 3 ☐
    - Yes, 5 or more times a week 4 ☐

19. Do you ever use an over-the-counter medicine (like Benadryl or Tylenol PM) to help you sleep?
    - No, not in the past 4 weeks 0 ☐
    - Yes, less than once a week 1 ☐
    - Yes, 1-2 times a week 2 ☐
    - Yes, 3-4 times a week 3 ☐
    - Yes, 5 or more times a week 4 ☐

ID NUMBER:									FORM CODE: SQE VERSION: A 08/10/10	Contact Occasion			SEQ #			

20. Do you ever use a prescription medicine (like trazodone or Ambien) to help you sleep?
    - No, not in the past 4 weeks 0 ☐
    - Yes, less than once a week 1 ☐
    - Yes, 1-2 times a week 2 ☐
    - Yes, 3-4 times a week 3 ☐
    - Yes, 5 or more times a week 4 ☐

21. On a typical day, how many cups of regular coffee (with caffeine) do you drink?

    ☐☐ cups

22. On a typical day, how many cups of regular tea (with caffeine) do you drink?

    ☐☐ cups

23. On a typical day, how many glasses or cans of cola or other soda with caffeine do you drink?

    ☐☐ glasses or cans

24. One a typical day, how many shots, cans or bottles of a caffeinated energy drink do you drink?

    ☐☐ shots, cans or bottles

25. Do you ever use caffeinated drinks (coffee, soda, energy drinks, etc.) to help you stay awake?
    - No, not in the past 4 weeks 0 ☐
    - Yes, less than once a week 1 ☐
    - Yes, 1-2 times a week 2 ☐
    - Yes, 3-4 times a week 3 ☐
    - Yes, 5 or more times a week 4 ☐

Sleep Questionnaire II_Spanish
HCHS/SOL Sleep Ancillary Study

ID NUMBER:									FORM CODE: SQS VERSION: A 10/14/10	Contact Occasion			SEQ #		

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.

Marque la respuesta por cada pregunta que mejor lo/la describa durante ***<u>las últimas dos semanas.</u>***

1. Considerando únicamente su propio ritmo, ¿a qué hora se levantaría usted si fuera enteramente libre para planificar el día?

5:00 – 6:30 am	1 ☐
6:30 – 7:45 am	2 ☐
7:45 – 9:45 am	3 ☐
9:45 – 11:00 am	4 ☐
11:00 am – 12:00 (mediodía)	5 ☐

2. Durante la primera media hora después de haberse despertado por la mañana se encuentra usted

Muy cansado	1 ☐
Bastante cansado	2 ☐
Bastante descanzado	3 ☐
Muy descanzado	4 ☐

3. ¿A qué hora de la noche se encuentra usted cansado y siente la necesidad de dormir?

8:00 – 9:00 pm	1 ☐
9:00 – 10:15 pm	2 ☐
10:15 pm – 12:45 am	3 ☐
12:45 – 2:00 am	4 ☐
2:00 – 3:00 am	5 ☐

4. ¿A qué hora del día cree que se encuentra mejor?

5:00 – 8:00 am	1 ☐
8:00– 10:00 am	2 ☐
10:00– 4:45 pm	3 ☐
5:00 – 9:45 pm	4 ☐
10:00– 4:45 am	5 ☐

5. Suele hablarse de personas de tipo "matutino" y "vespertino". ¿De cuál de estos dos tipos se considera usted?

Claramente funciono mejor en la mañana.	1 ☐
Funciono más en la mañana que en la tarde.	2 ☐
Funciono más en la tarde que en la mañana.	3 ☐
Claramente funciono mejor en la tarde.	4 ☐

ID NUMBER:								FORM CODE: SQS VERSION: A 10/14/10	Contact Occasion			SEQ #			

Marque la respuesta por cada pregunta que mejor lo/la describa durante ***<u>las últimas dos semanas.</u>***

6. Indique la severidad de su dificultad para iniciar el sueño.
   - Ninguna 0 ☐
   - Ligera 1 ☐
   - Moderada 2 ☐
   - Grave 3 ☐
   - Mucha 4 ☐

7. Indique la severidad de su dificultad para mantener el sueño.
   - Ninguna 0 ☐
   - Ligera 1 ☐
   - Moderada 2 ☐
   - Grave 3 ☐
   - Mucha 4 ☐

8. Indique la severidad de que se despierta demasiado pronto:
   - Ninguna 0 ☐
   - Ligera 1 ☐
   - Moderada 2 ☐
   - Grave 3 ☐
   - Mucha 4 ☐

9. Indique como está usted de satisfecho/descontento con su patrón de sueño actual:
   - Muy Satisfecho 0 ☐
   - Satisfecho 1 ☐
   - Ni satisfecho ni descontento 2 ☐
   - No Satisfecho 3 ☐
   - Muy descontento 4 ☐

10. En las últimas dos semanas, ¿ha tenido problemas con su sueño?
    - No 0 ☐ → GO TO QUESTION 14
    - Sí 1 ☐

11. Indique hasta que punto considera que su problema del sueño **INTERFIERE** en su funcionamiento diario (rendimiento en el trabajo o en sus tareas diarias, fatiga, concentración, memoria, estado emocional, etc.):
    - En absoluto 0 ☐
    - Un poco 1 ☐
    - Bastante 2 ☐
    - Mucho 3 ☐
    - Muchísimo 4 ☐

12. Indique hasta que punto los demás se dan cuenta de su problema de sueño y de lo que deteriora su calidad de vida:
    - En absoluto 0 ☐
    - Un poco 1 ☐
    - Bastante 2 ☐
    - Mucho 3 ☐
    - Muchísimo 4 ☐

ID NUMBER:								FORM CODE: SQS VERSION: A 10/14/10	Contact Occasion			SEQ #			

13. Indique hasta que punto le preocupa su problema de sueño actual:
    - En absoluto 0 ☐
    - Un poco 1 ☐
    - Bastante 2 ☐
    - Mucho 3 ☐
    - Muchísimo 4 ☐

14. ¿Tiene una televisión en su cuarto?
    - No 0 ☐ → GO TO QUESTION 16
    - Sí 1 ☐

En esta sección, por favor marque la respuesta por cada pregunta que mejor lo/la describa durante ***las últimas cuatro semanas.***

15. ¿Alguna vez usa la televisión para ayudarse a dormir?
    - No, no en las últimas 4 semanas 0 ☐
    - Sí, menos de una vez por semana 1 ☐
    - Sí, 1-2 veces a la semana 2 ☐
    - Sí, 3-4 veces a la semana 3 ☐
    - Sí, 5 o más veces a la semana 4 ☐

16. ¿Alguna vez ha tomado un trago de alcohol para ayudarse a dormir?
    - No, no en las últimas 4 semanas 0 ☐
    - Sí, menos de una vez por semana 1 ☐
    - Sí, 1-2 veces a la semana 2 ☐
    - Sí, 3-4 veces a la semana 3 ☐
    - Sí, 5 o más veces a la semana 4 ☐

17. ¿Alguna vez ha tomado una bebida no alcohólica como leche caliente o té de hierbas para ayudarse a dormir?
    - No, no en las últimas 4 semanas 0 ☐
    - Sí, menos de una vez por semana 1 ☐
    - Sí, 1-2 veces a la semana 2 ☐
    - Sí, 3-4 veces a la semana 3 ☐
    - Sí, 5 o más veces a la semana 4 ☐

18. ¿Alguna vez ha tomado medicinas a base de hierbas o naturales (como melatonina o valeriana) para ayudarse a dormir?
    - No, no en las últimas 4 semanas 0 ☐
    - Sí, menos de una vez por semana 1 ☐
    - Sí, 1-2 veces a la semana 2 ☐
    - Sí, 3-4 veces a la semana 3 ☐
    - Sí, 5 o más veces a la semana 4 ☐

19. ¿Alguna vez ha tomado medicamentos sin receta (como Benadryl o Tylenol PM) para ayudarse a dormir?
    - No, no en las últimas 4 semanas 0 ☐
    - Sí, menos de una vez por semana 1 ☐
    - Sí, 1-2 veces a la semana 2 ☐
    - Sí, 3-4 veces a la semana 3 ☐
    - Sí, 5 o más veces a la semana 4 ☐

ID NUMBER:									FORM CODE: SQS VERSION: A 10/14/10	Contact Occasion			SEQ #			

20. ¿Alguna vez ha tomado medicamentos con receta (como trazodone o Ambien) para ayudarse a dormir?

No, no en las últimas 4 semanas 0 ☐
Sí, menos de una vez por semana 1 ☐
Sí, 1-2 veces a la semana 2 ☐
Sí, 3-4 veces a la semana 3 ☐
Sí, 5 o mas veces a la semana 4 ☐

21. En un día típico, ¿cuántas tazas de café regular (con cafeína) toma?

☐☐ tazas

22. En un día típico, ¿ cuántas tazas de té regular (con cafeína) toma?

☐☐ tazas

23. En un día típico, ¿ cuántos vasos o latas de cola u otra soda con cafeína toma?

☐☐ vasos o latas

24. En un día típico, ¿ cuántos tragos, latas o botellas de bebidas energéticas con cafeína toma?

☐☐ tragos, latas o botellas

25. ¿Alguna vez usa bebidas con cafeína (café, té, soda, o bebidas energéticas) para ayudarse a mantenerse despierto?

No, no en las últimas 4 semanas 0 ☐
Sí, menos de una vez por semana 1 ☐
Sí, 1-2 veces a la semana 2 ☐
Sí, 3-4 veces a la semana 3 ☐
Sí, 5 o más veces a la semana 4 ☐

Sueño – Sleep Habits in HCHS/SOL

Sleep Questionnaire II (SQE/SQS) Question by Question Instructions

General Instructions:
This section of the interview asks additional questions about sleep patterns and impact of sleep problems. These questions also explore sleep issues more in depth and/or assess different areas of sleep such as circadian rhythms, insomnia, and sleep hygiene.

Question by Question Instructions:

Q1-5. These questions make up the Horne and Östberg Reduced Morningness and Eveningness Questionnaire used to assess the participant's biological rhythm. Emphasize that the responses given in this section should pertain to the PAST 2 WEEKS. The answer choices for Q1, Q3 andQ4 are ranges in clock time. DO NOT present the answer choices to the participant initially. Instead, allow the participant to tell you the time of day and mark the corresponding answer choice. For these questions, if a participant answers a time that is earlier than the earliest answer choice, mark the earliest choice. If a participant answers a time that is later than the latest answer choose, mark the latest choice. If the participant reports a time that corresponds to multiple answer choices, read both answer choices to the participant and ask them to choose the best choice.

Q1. The goal of this question is to understand the timing of the participant's internal clock. Therefore, the question is in regards to what time the participant would wake up from sleep if he/she had no responsibilities (getting to work, taking children to school) to worry about and could organize their own day. Allow the participant to tell you the time of day and mark the corresponding answer choice.

Q2. This question asks how the participant feels after waking at their normal waking time, not the time they chose on Q1.

Q4 A participant's "feeling best" peak is the time when the participant feels the most alert and energized. If the participant is unsure what a "feeling best" peak means, define this term as the time they feel the most alert and full of energy. Allow the participant to tell you the time of day and mark the corresponding answer choice.

Q5 If the participant is unsure what "morning" and "evening" types of people are, define these terms. A "morning" type tends to be more alert and full of energy in the morning whereas an "evening" type tends to be more alert and full of energy in the evening.

Q6-Q13. These questions make up the Insomnia Severity Index. Emphasize that for these questions that the participant is supposed to think about their PAST 2 WEEKS of sleep when answering these questions. Some participants do not have any insomnia symptoms ('no' response to Q10); in this case Q11-13 will be skipped.

Q6. This question refers to the severity of the participant's difficulty getting to sleep after turning off the lights for their longest sleep period.

Q7. This question refers to the severity of the participant's difficulty staying asleep for their longest sleep period. This can be because he/she wakes up frequently or has difficulty falling back to sleep after having woken up.

Q8. This question refers to the severity of the participant's ability to sleep for the entire time set aside for sleep – waking up earlier than they intended or needed to, or earlier than the alarm clock was set – with regards to their longest sleep period.

Q9. This question refers to the participant's overall sleep pattern, not their sleep quality. Their sleep pattern includes when they are able to fall asleep and wake up, duration, and whether they nap. For instance, a participant may not be satisfied with the fact that he is not able to sleep at night, so he has to nap during the day and that impedes him from doing other activities.

Q10. This question assesses whether or not the participant feels like they have any problem with their sleep. This could include poor quality sleep or trouble falling/staying asleep. If participants answer 'no' to this question, skip to Q14

Q11. If participant answers 'yes' to Q10, then ask Q11. This question asks the participant to think of the problem or problems they indicated in Q10 and describe the level to which these problems interfere with their daily functioning.

Q12. If participant answers 'yes' to Q10, then ask Q12. Again, participants are supposed to refer to the problem(s) mentioned in Q10. For this question the participant is asked to describe how noticeable the impairment caused by their sleep problem or problems is to others.

Q13. If participant answers 'yes' to Q10, then ask Q13. Again, participants are supposed to refer to the problem(s) mentioned in Q10. For this question, participants are asked to describe how distressed or worried they are about their sleep problem or problems.

Q14. This question assesses whether the participant has a television in the room that they usually sleep in. The television must be functioning. However, it does not matter whether the participant watches television in that room. If a participant answers 'no' to this question, then skip to Q16.

Q15-20. These questions assess whether the participant uses any activity or supplement to help them fall asleep. Emphasize that this is in the PAST 4 WEEKS. Only mark 'yes' if the participant intentionally does these activities with the purpose of helping them fall or stay asleep.

Q21-22. For these questions emphasize that we are assessing how many cups of CAFFEINATED coffee or tea they may drink in a typical day over the PAST 4 WEEKS. If participant asks for clarification, a cup is 8oz or about the size of a typical, small Styrofoam cup. For example the "venti" (20oz) size from Starbucks would count as 2 cups on these questions. If a participant drinks "half-caf" (half regular and half decaffeinated coffee) then divide however many cups they drink per day by 2 (if this does not equal a whole number round up to the nearest whole number).

Q23. Again, emphasize that the participant should only include caffeinated soda intake per day over the past four weeks. Lemon-lime soda and root-beer, among others, do not usually include caffeine. If the participant asks for clarification, a can of soda is 12oz. If someone drinks a 20oz bottle of soda that would count as 2 glasses or cans of soda. If someone drinks a 2 liter bottle of soda that would count as 5 glasses or cans.

Q24. Again, emphasize that the participant should only count caffeinated energy drinks . Energy drinks come in all sizes, so just record the number of individually packaged (shots, cans, bottles) caffeinated energy drinks that the participant ingests on a typical day.

Acculturation Stress
HCHS/SOL Sleep Ancillary Study

ID NUMBER:									FORM CODE: ATE VERSION: A 04/01/10	Contact Occasion			SEQ #		

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.

Acculturation Stress: Hispanic Stress Inventory

Please answer 'yes' or 'no' to indicate whether the following situations have occurred to you during the last 3 months. Then if it did occur to you, indicate how worried or tense the situation made you feel. Remember there is no right or wrong answer so try and be as honest as you can.

1. Because I do not know enough English, it has been difficult for me to interact with others.

No 0 ☐ → **GO TO QUESTION 2**
Yes 1 ☐

1a. How worried or tense have you been about it?

Not at all worried/tense 1 ☐
A little worried/tense 2 ☐
Moderately worried/tense 3 ☐
Very worried/tense 4 ☐
Extremely worried/tense 5 ☐

2. My spouse and I have disagreed on how to bring up our children.

No 0 ☐ → **GO TO QUESTION 3**
Yes 1 ☐
N/A 9 ☐ → **GO TO QUESTION 3**

2a. How worried or tense have you been about it?

Not at all worried/tense 1 ☐
A little worried/tense 2 ☐
Moderately worried/tense 3 ☐
Very worried/tense 4 ☐
Extremely worried/tense 5 ☐

3. Because of my poor English people have treated me badly.

No 0 ☐ → **GO TO QUESTION 4**
Yes 1 ☐

ID NUMBER:								FORM CODE: ATE VERSION: A 04/01/10	Contact Occasion			SEQ #			

3a. How worried or tense have you been about it?

Not at all worried/tense 1 ☐
A little worried/tense 2 ☐
Moderately worried/tense 3 ☐
Very worried/tense 4 ☐
Extremely worried/tense 5 ☐

4. My children have not respected my authority the way they should.

No 0 ☐ → **GO TO QUESTION 5**
Yes 1 ☐
N/A 9 ☐ → **GO TO QUESTION 5**

4a. How worried or tense have you been about it?

Not at all worried/tense 1 ☐
A little worried/tense 2 ☐
Moderately worried/tense 3 ☐
Very worried/tense 4 ☐
Extremely worried/tense 5 ☐

5. Because I am Latino I have been expected to work harder.

No 0 ☐ → **GO TO QUESTION 6**
Yes 1 ☐

5a. How worried or tense have you been about it?

Not at all worried/tense 1 ☐
A little worried/tense 2 ☐
Moderately worried/tense 3 ☐
Very worried/tense 4 ☐
Extremely worried/tense 5 ☐

6. My income has not been sufficient to support my family or myself.

No 0 ☐ → **GO TO QUESTION 7**
Yes 1 ☐

6a. How worried or tense have you been about it?

Not at all worried/tense 1 ☐
A little worried/tense 2 ☐
Moderately worried/tense 3 ☐
Very worried/tense 4 ☐
Extremely worried/tense 5 ☐

7. I have felt that my children's ideas about sexuality are too liberal.

No 0 ☐ → **GO TO QUESTION 8**
Yes 1 ☐
N/A 9 ☐ → **GO TO QUESTION 8**

7a. How worried or tense have you been about it?

Not at all worried/tense 1 ☐
A little worried/tense 2 ☐
Moderately worried/tense 3 ☐
Very worried/tense 4 ☐
Extremely worried/tense 5 ☐

ID NUMBER:								FORM CODE: ATE VERSION: A 04/01/10	Contact Occasion			SEQ #			

8. There has been physical violence among members of my family.

No 0 ☐ → **GO TO QUESTION 9**
Yes 1 ☐

8a. How worried or tense have you been about it?

Not at all worried/tense 1 ☐
A little worried/tense 2 ☐
Moderately worried/tense 3 ☐
Very worried/tense 4 ☐
Extremely worried/tense 5 ☐

9. Because I am Latino I have had difficulty finding the type of work I want.

No 0 ☐ → **GO TO QUESTION 10**
Yes 1 ☐

9a. How worried or tense have you been about it?

Not at all worried/tense 1 ☐
A little worried/tense 2 ☐
Moderately worried/tense 3 ☐
Very worried/tense 4 ☐
Extremely worried/tense 5 ☐

10. My children have talked about leaving home.

No 0 ☐ → **GO TO QUESTION 11**
Yes 1 ☐
N/A 9 ☐ → **GO TO QUESTION 11**

10a. How worried or tense have you been about it?

Not at all worried/tense 1 ☐
A little worried/tense 2 ☐
Moderately worried/tense 3 ☐
Very worried/tense 4 ☐
Extremely worried/tense 5 ☐

11. My children have received bad school reports (or bad grades).

No 0 ☐ → **GO TO QUESTION 12**
Yes 1 ☐
N/A 9 ☐ → **GO TO QUESTION 12**

11a. How worried or tense have you been about it?

Not at all worried/tense 1 ☐
A little worried/tense 2 ☐
Moderately worried/tense 3 ☐
Very worried/tense 4 ☐
Extremely worried/tense 5 ☐

12. I have had to watch the quality of my work so others do not think I am lazy.

No 0 ☐ → **GO TO QUESTION 13**
Yes 1 ☐

ID NUMBER:								FORM CODE: ATE VERSION: A 04/01/10	Contact Occasion			SEQ #			

12a. How worried or tense have you been about it?

Not at all worried/tense 1 ☐
A little worried/tense 2 ☐
Moderately worried/tense 3 ☐
Very worried/tense 4 ☐
Extremely worried/tense 5 ☐

13. Because I am Latino it has been hard to get promotions or salary raises.

No 0 ☐ → **GO TO QUESTION 14**
Yes 1 ☐

13a. How worried or tense have you been about it?

Not at all worried/tense 1 ☐
A little worried/tense 2 ☐
Moderately worried/tense 3 ☐
Very worried/tense 4 ☐
Extremely worried/tense 5 ☐

14. I had serious arguments with family members.

No 0 ☐ → **GO TO QUESTION 15**
Yes 1 ☐

14a. How worried or tense have you been about it?

Not at all worried/tense 1 ☐
A little worried/tense 2 ☐
Moderately worried/tense 3 ☐
Very worried/tense 4 ☐
Extremely worried/tense 5 ☐

15. I have been forced to accept low paying jobs.

No 0 ☐ → **GO TO QUESTION 16**
Yes 1 ☐

15a. How worried or tense have you been about it?

Not at all worried/tense 1 ☐
A little worried/tense 2 ☐
Moderately worried/tense 3 ☐
Very worried/tense 4 ☐
Extremely worried/tense 5 ☐

16. There have been conflicts among members of my family.

No 0 ☐ → **GO TO QUESTION 17**
Yes 1 ☐

16a. How worried or tense have you been about it?

Not at all worried/tense 1 ☐
A little worried/tense 2 ☐
Moderately worried/tense 3 ☐
Very worried/tense 4 ☐
Extremely worried/tense 5 ☐

ID NUMBER:									FORM CODE: ATE VERSION: A 04/01/10	Contact Occasion			SEQ #			

17. I have felt pressured to learn English.

No 0 ☐ → **END QUESTIONNAIRE**
Yes 1 ☐

17a. How worried or tense have you been about it?

Not at all worried/tense 1 ☐
A little worried/tense 2 ☐
Moderately worried/tense 3 ☐
Very worried/tense 4 ☐
Extremely worried/tense 5 ☐

Acculturation Stress_Spanish
HCHS/SOL Sleep Ancillary Study

ID NUMBER:									FORM CODE: ATS VERSION: A 09/01/10	Contact Occasion			SEQ #		

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.

Acculturation Stress: Hispanic Stress Inventory

*Por favor responda "sí" o "no" para indicar si las siguientes situaciones le han ocurrido a usted en los últimos **3 meses**. Si le ocurrieron, indique que tan preocupado o tenso la situación lo ha hecho sentir. Si la situación mencionada no le ha ocurrido, conteste "no". Recuerde, no hay respuestas correctas o incorrectas. Por favor trate de ser honesto(a) con sus respuestas.*

1. Por no saber suficiente inglés ha sido difícil para mí socializar con otros.

No 0 ☐ → **GO TO QUESTION 2**
Sí 1 ☐

1a. ¿Qué tan preocupado(a) o tenso(a) ha estado?

No preocupado/tenso 1 ☐
Un poco preocupado/tenso 2 ☐
Moderadamente preocupado/tenso 3 ☐
Muy preocupado/tenso 4 ☐
Extremadamente preocupado/tenso 5 ☐

2. Mi esposo(a) y yo hemos tenido desacuerdos acerca de cómo criar a nuestros hijos.

No 0 ☐ → **GO TO QUESTION 3**
Sí 1 ☐
N/A 9 ☐ → **GO TO QUESTION 3**

2a. ¿Qué tan preocupado(a) o tenso(a) ha estado?

No preocupado/tenso 1 ☐
Un poco preocupado/tenso 2 ☐
Moderadamente preocupado/tenso 3 ☐
Muy preocupado/tenso 4 ☐
Extremadamente preocupado/tenso 5 ☐

3. Debido a mi mal inglés, la gente me ha tratado mal.

No 0 ☐ → **GO TO QUESTION 4**
Sí 1 ☐

3a. ¿Qué tan preocupado(a) o tenso(a) ha estado?

No preocupado/tenso	1 ☐
Un poco preocupado/tenso	2 ☐
Moderadamente preocupado/tenso	3 ☐
Muy preocupado/tenso	4 ☐
Extremadamente preocupado/tenso	5 ☐

4. Mis hijos(as) no han respetado mi autoridad en la forma que deberían.

No	0 ☐	→ **GO TO QUESTION 5**
Sí	1 ☐	
N/A	9 ☐	→ **GO TO QUESTION 5**

4a. ¿Qué tan preocupado(a) o tenso(a) ha estado?

No preocupado/tenso	1 ☐
Un poco preocupado/tenso	2 ☐
Moderadamente preocupado/tenso	3 ☐
Muy preocupado/tenso	4 ☐
Extremadamente preocupado/tenso	5 ☐

5. Debido a que soy latino(a) se ha esperado que trabaje más duro.

No	0 ☐	→ **GO TO QUESTION 6**
Sí	1 ☐	

5a. ¿Qué tan preocupado(a) o tenso(a) ha estado?

No preocupado/tenso	1 ☐
Un poco preocupado/tenso	2 ☐
Moderadamente preocupado/tenso	3 ☐
Muy preocupado/tenso	4 ☐
Extremadamente preocupado/tenso	5 ☐

6. Mis ingresos no han sido suficientes para mantener a mi familia o a mí mismo/a.

No	0 ☐	→ **GO TO QUESTION 7**
Sí	1 ☐	

6a. ¿Qué tan preocupado(a) o tenso(a) ha estado?

No preocupado/tenso	1 ☐
Un poco preocupado/tenso	2 ☐
Moderadamente preocupado/tenso	3 ☐
Muy preocupado/tenso	4 ☐
Extremadamente preocupado/tenso	5 ☐

7. He sentido que las ideas de mis hijos(as) acerca de la sexualidad son demasiado liberales.

No	0 ☐	→ **GO TO QUESTION 8**
Sí	1 ☐	
N/A	9 ☐	→ **GO TO QUESTION 8**

7a. ¿Qué tan preocupado(a) o tenso(a) ha estado?

No preocupado/tenso	1 ☐
Un poco preocupado/tenso	2 ☐
Moderadamente preocupado/tenso	3 ☐
Muy preocupado/tenso	4 ☐
Extremadamente preocupado/tenso	5 ☐

8. Ha habido violencia física entre miembros de mi familia.

No	0 ☐	→ **GO TO QUESTION 9**
Sí	1 ☐	

8a. ¿Qué tan preocupado(a) o tenso(a) ha estado?

No preocupado/tenso	1 ☐
Un poco preocupado/tenso	2 ☐
Moderadamente preocupado/tenso	3 ☐
Muy preocupado/tenso	4 ☐
Extremadamente preocupado/tenso	5 ☐

9. Debido a que soy latino(a) he tenido dificultad para encontrar el tipo de trabajo que quiero.

No	0 ☐	→ **GO TO QUESTION 10**
Sí	1 ☐	

9a. ¿Qué tan preocupado(a) o tenso(a) ha estado?

No preocupado/tenso	1 ☐
Un poco preocupado/tenso	2 ☐
Moderadamente preocupado/tenso	3 ☐
Muy preocupado/tenso	4 ☐
Extremadamente preocupado/tenso	5 ☐

10. Mis hijos(as) han hablado acerca de irse de la casa.

No	0 ☐	→ **GO TO QUESTION 11**
Sí	1 ☐	
N/A	9 ☐	→ **GO TO QUESTION 11**

10a. ¿Qué tan preocupado(a) o tenso(a) ha estado?

No preocupado/tenso	1 ☐
Un poco preocupado/tenso	2 ☐
Moderadamente preocupado/tenso	3 ☐
Muy preocupado/tenso	4 ☐
Extremadamente preocupado/tenso	5 ☐

11. Mis hijos(as) han recibido malas calificaciones en la escuela.

No	0 ☐	→ **GO TO QUESTION 12**
Sí	1 ☐	
N/A	9 ☐	→ **GO TO QUESTION 12**

11a. ¿Qué tan preocupado(a) o tenso(a) ha estado?

No preocupado/tenso	1 ☐
Un poco preocupado/tenso	2 ☐
Moderadamente preocupado/tenso	3 ☐
Muy preocupado/tenso	4 ☐
Extremadamente preocupado/tenso	5 ☐

12. He tenido que ser cuidadoso(a) con la calidad de mi trabajo para que otros no piensen que soy un(a) perezoso(a).

No	0 ☐	→ **GO TO QUESTION 13**
Sí	1 ☐	

12a. ¿Qué tan preocupado(a) o tenso(a) ha estado?

No preocupado/tenso	1 ☐
Un poco preocupado/tenso	2 ☐
Moderadamente preocupado/tenso	3 ☐
Muy preocupado/tenso	4 ☐
Extremadamente preocupado/tenso	5 ☐

13. Debido a que soy latino(a), ha sido difícil obtener ascensos o aumentos de salario.

No	0 ☐	→ **GO TO QUESTION 14**
Sí	1 ☐	

13a. ¿Qué tan preocupado(a) o tenso(a) ha estado?

No preocupado/tenso	1 ☐
Un poco preocupado/tenso	2 ☐
Moderadamente preocupado/tenso	3 ☐
Muy preocupado/tenso	4 ☐
Extremadamente preocupado/tenso	5 ☐

14. He tenido pleitos serios con miembros de mi familia.

No	0 ☐	→ **GO TO QUESTION 15**
Sí	1 ☐	

14a. ¿Qué tan preocupado(a) o tenso(a) ha estado?

No preocupado/tenso	1 ☐
Un poco preocupado/tenso	2 ☐
Moderadamente preocupado/tenso	3 ☐
Muy preocupado/tenso	4 ☐
Extremadamente preocupado/tenso	5 ☐

15. Me he visto forzado(a) a aceptar trabajos con salarios bajos.

No	0 ☐	→ **GO TO QUESTION 16**
Sí	1 ☐	

15a. ¿Qué tan preocupado(a) o tenso(a) ha estado?

No preocupado/tenso	1 ☐
Un poco preocupado/tenso	2 ☐
Moderadamente preocupado/tenso	3 ☐
Muy preocupado/tenso	4 ☐
Extremadamente preocupado/tenso	5 ☐

16. Ha habido pleitos entre miembros de mi familia.

No 0 ☐ → **GO TO QUESTION 17**
Sí 1 ☐

16a. ¿Qué tan preocupado(a) o tenso(a) ha estado?

No preocupado/tenso 1 ☐
Un poco preocupado/tenso 2 ☐
Moderadamente preocupado/tenso 3 ☐
Muy preocupado/tenso 4 ☐
Extremadamente preocupado/tenso 5 ☐

17. Me he sentido presionado(a) para aprender inglés.

No 0 ☐ → **END QUESTIONNAIRE**
Sí 1 ☐

17a. ¿Qué tan preocupado(a) o tenso(a) ha estado?

No preocupado/tenso 1 ☐
Un poco preocupado/tenso 2 ☐
Moderadamente preocupado/tenso 3 ☐
Muy preocupado/tenso 4 ☐
Extremadamente preocupado/tenso 5 ☐

Sueño – Sleep Habits in HCHS/SOL

Acculturation Stress (ATE/ATS) Question by Question Instructions

General Instructions: Hispanic Stress Inventory (HIS)

The HSI acculturation stress measure is a 17-item measure created for Latinos that taps stress associated with the process of integrating and existing in a non-native culture. Various aspects of acculturation such as language ability, relationships with children, work opportunities, family conflicts and moral standards are addressed. You should be aware of skip patterns for several of the questions and be sure to follow them as directed. It is important to present all answers to the participant including N/A (Not Applicable). Make sure to tell the participant that N/A (Not Applicable) should be the answer choice given if the participant does not have children in response to questions that ask about children. If the participant says "No" in response to a question asking about children, confirm that the participant is NOT responding this way because they do not have children. Note that all the questions must be read to the participant and request that he/she responded N/A (Not Applicable) regardless of if the participant verbally indicates he/she has no children or is not married.

Q1-Q17a: Read the script exactly as it appears. You may re-read the answer options if the participant requests. When asking these questions, be careful to not comment on respondent's answers and to record answers in a non-judgmental manner. If you are asked about the meaning of specific questions, you should encourage participants to interpret questions in the way that makes the most sense to them. It is critical that you do not provide definitions or interpretations of these questions.

Well-Being Questionnaire
HCHS/SOL Sleep Ancillary Study

ID NUMBER:									FORM CODE: WLE VERSION: A 08/16/10	Contact Occasion			SEQ #		

ADMINISTRATIVE INFORMATION

0a. Completion Date: ☐☐/☐☐/☐☐☐☐ 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.

A. CES-D 10

I am going to read a list of some of the ways you may have felt or behaved. Please indicate how often you have felt this way during the past week. Respond by saying "rarely or none of the time', meaning less than one day during the past week, 'some or a little of the time', meaning one to two days during the past week, 'occasionally or a moderate amount of time, meaning three to four days, or 'all of the time' meaning five to seven days. Choose only one of these categories for each item statement I read.

	Rarely or none of the time (<1 day)	Some or a little of the time (1-2 days)	Occasionally or a moderate amount of time (3-4 days)	All of the time (5-7 days)
1. I was bothered by things that usually don't bother me.	0 ☐	1 ☐	2 ☐	3 ☐
2. I had trouble keeping my mind on what I was doing.	0 ☐	1 ☐	2 ☐	3 ☐
3. I felt depressed.	0 ☐	1 ☐	2 ☐	3 ☐
4. I felt that everything I did was an effort.	0 ☐	1 ☐	2 ☐	3 ☐
5. I felt hopeful about the future.	0 ☐	1 ☐	2 ☐	3 ☐
6. I felt fearful.	0 ☐	1 ☐	2 ☐	3 ☐
7. My sleep was restless.	0 ☐	1 ☐	2 ☐	3 ☐
8. I was happy.	0 ☐	1 ☐	2 ☐	3 ☐
9. I felt lonely.	0 ☐	1 ☐	2 ☐	3 ☐
10. I could not "get going".	0 ☐	1 ☐	2 ☐	3 ☐

ID NUMBER:								FORM CODE: WLE VERSION: A 08/16/10	Contact Occasion			SEQ #		

B. Spielberger Trait Anxiety Scale

I am now going to read you another list of statements. Do not spend too much time on any one statement but give the answer which seems to describe how you generally feel.

	Almost never	Sometimes	Often	Almost always
11. I feel nervous and restless.	0 ☐	1 ☐	2 ☐	3 ☐
12. I feel satisfied with myself.	0 ☐	1 ☐	2 ☐	3 ☐
13. I wish I could be as happy as others seem to be.	0 ☐	1 ☐	2 ☐	3 ☐
14. I feel like a failure.	0 ☐	1 ☐	2 ☐	3 ☐
15. I worry too much over something that really doesn't matter.	0 ☐	1 ☐	2 ☐	3 ☐
16. I lack self-confidence.	0 ☐	1 ☐	2 ☐	3 ☐
17. I feel secure.	0 ☐	1 ☐	2 ☐	3 ☐
18. I feel inadequate.	0 ☐	1 ☐	2 ☐	3 ☐
19. I am a steady person.	0 ☐	1 ☐	2 ☐	3 ☐
20. I get in a state of tension or turmoil as I think over my recent concerns and interests.	0 ☐	1 ☐	2 ☐	3 ☐

Well-Being Questionnaire_Spanish
HCHS/SOL Sleep Ancillary Study

ID NUMBER:									FORM CODE: WLS VERSION: A 08/30/10	Contact Occasion			SEQ #		

ADMINISTRATIVE INFORMATION

0a. Completion Date: ☐☐/☐☐/☐☐☐☐ 0b. Staff ID: ☐☐☐

Instructions: Mark the appropriate box for the response. Unless instructed, mark ONLY one response.

A. CES-D 10

Aquí le presento una lista de frases que describen cómo pudo haberse sentido o comportado. Por favor, indique con qué frecuencia se ha sentido de esta manera durante la semana pasada. Puede responder con 'raramente o ninguna vez', que significa menos de un día a la semana, 'algunas veces o pocas veces, que significa uno a dos días a la semana, 'ocasionalmente o una cantidad de tiempo moderado', que significa tres o cuatro días a la semana o 'la mayor parte del tiempo, que significa cinco a siete días a la semana. Escoja una opción para cada frase.

	Raramente o ninguna vez (<1 día)	Algunas o pocas veces (1-2 días)	Ocasionalmente o una cantidad de tiempo moderado (3-4 días)	La mayor parte del tiempo (5-7 días)
1. Me molestaron cosas que usualmente no me molestan.	0 ☐	1 ☐	2 ☐	3 ☐
2. Tuve dificultad en mantener mi mente en lo que hacía.	0 ☐	1 ☐	2 ☐	3 ☐
3. Me sentí deprimido(a).	0 ☐	1 ☐	2 ☐	3 ☐
4. Sentí que todo lo que hacía era un esfuerzo.	0 ☐	1 ☐	2 ☐	3 ☐
5. Me sentí con esperanza en el futuro.	0 ☐	1 ☐	2 ☐	3 ☐
6. Me sentí con miedo.	0 ☐	1 ☐	2 ☐	3 ☐
7. Mi sueño fue inquieto.	0 ☐	1 ☐	2 ☐	3 ☐
8. Estuve contento(a).	0 ☐	1 ☐	2 ☐	3 ☐
9. Me sentí solo(a).	0 ☐	1 ☐	2 ☐	3 ☐
10. No tuve ganas de hacer nada.	0 ☐	1 ☐	2 ☐	3 ☐

ID NUMBER:								FORM CODE: WLS VERSION: A 08/30/10	Contact Occasion			SEQ #		

B. Spielberger Trait Anxiety Scale

Ahora le voy a presentar otra lista de frases. No tome mucho tiempo en cada frase pero escoja la respuesta que describa mejor cómo se siente generalmente.

	Casi nunca	A veces	A menudo	Casi siempre
11. Me siento nervioso(a) e inquieto(a).	0 ☐	1 ☐	2 ☐	3 ☐
12. Me siento satisfecho(a) conmigo mismo(a).	0 ☐	1 ☐	2 ☐	3 ☐
13. Desearía que pudiera ser tan feliz como otras personas parecen serlo.	0 ☐	1 ☐	2 ☐	3 ☐
14. Siento que soy un fracaso.	0 ☐	1 ☐	2 ☐	3 ☐
15. Me preocupo mucho por algo que realmente no vale la pena.	0 ☐	1 ☐	2 ☐	3 ☐
16. No tengo confianza en mí mismo(a).	0 ☐	1 ☐	2 ☐	3 ☐
17. Me siento seguro(a).	0 ☐	1 ☐	2 ☐	3 ☐
18. Me siento inadecuado(a).	0 ☐	1 ☐	2 ☐	3 ☐
19. Soy una persona estable.	0 ☐	1 ☐	2 ☐	3 ☐
20. Me siento en un estado agitado y tenso cuando pienso en mis preocupaciones e intereses recientes.	0 ☐	1 ☐	2 ☐	3 ☐

Sueño – Sleep Habits in HCHS/SOL

Well Being (WLE/WLS) Question by Question Instructions

General Instructions:
The Well-being questionnaire consists of two brief measures that assess depressive symptoms and "trait anxiety", respectively. Measures included are the Center for Epidemiological Study measure of depression (10- item version) and the Spielberger Trait Anxiety Scale (10-item version) in order to evaluate the relationships between depression and anxiety with sleep in this population. In addition, these measures will allow an assessment of the prevalence of depression and anxiety symptoms among Latinos that have sleep problems.

Question by Question Instructions:
Q1 – Q10:
The CESD 10 is a measure of thoughts or feelings related to recent depression. Interviewers should read the script exactly as it appears on the screen. Emphasis should be placed on the time frame, the PAST WEEK. Interviewers should then read the answers and let respondents know that for each question there will be 4 possible answers – rarely or none of the time (<1 day/week), some or little of the time (1-2 days/week), occasionally or a moderate amount of time (3-4 days/week), or all of the time (5-7 days/week). The number of days per week should be read to help the respondent understand each of the categories. In addition, hand motions to indicate the continuum from the low end of the scale to the high end of the scale can be helpful. Show cards or the instrument itself displaying the Likert scale when describing the answer categories. After describing the answer categories, the interviewer should proceed with asking each question and the corresponding answer categories. The interviewer may re-read the answer options if the participant has problems recalling them or choosing a category. When asking these questions, interviewers should be careful to not comment on respondent's answers and to record answers in a non-judgmental manner.

Q11 –Q20:
Trait anxiety reflects the existence of STABLE individual differences in the tendency to respond with an unpleasant emotional arousal in the anticipation of threatening situations. Interviewers should read the script exactly as it appears on the screen. The respondent should refer to how he or she GENERALLY feels. The interviewer may re-read the answer options if the participant has problems recalling them or choosing a category. BE CAREFUL. In contrast to the CES-D questions in 1-10, there is no reference to a specific time period in these questions. This is because the questions are designed to uncover a stable pattern of behavior. ONLY IF the individual asks for clarification on the time period, the interview can clarify by recommending that the respondent think about the PREVIOUS YEAR. When asking these questions, interviewers should be careful to not comment on respondent's answers and to record answers in a non-judgmental manner.

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ACTIWATCH INSTRUCTIONS

About the ActiWatch

What is it doing?

While it may look like a watch, the ActiWatch is actually a very complex and delicate machine. Inside, it has sensors that record when and how the watch moves which can tell us when you are awake and when you are asleep. It also has a light detector that tells us how much light you are exposed to. Wearing the ActiWatch will let us know about your sleep quantity and quality.

It is very important that the ActiWatch is cared for properly. Please follow the instructions on this page as well as those given by staff.

Wearing the ActiWatch

- For the next week, **please wear the ActiWatch as much as possible.**
- **The ActiWatch is waterproof** – it can be worn in the shower and while swimming.
- Wear the ActiWatch on the hand that you do not write with (if you are right handed, wear the watch on your left hand).
- Treat the ActiWatch like an expensive watch. **If you have to take it off, please keep it in a safe place.**
- There is a light sensor on the ActiWatch so please keep it uncovered (by clothing, etc.) as much as possible.
- There is a button on either side of the ActiWatch face. **Please press both buttons for 3 seconds to mark when you are going to sleep and when you wake up.**

Questions or Problems

If you have any questions or problems, call _____ at (_ _ _) _ _ _ - _ _ _ _.

Daily Sleep Log
HCHS/SOL Sleep Ancillary Study

ID NUMBER:										Form Code: DSE Version: A 09/15/10	Contact Occasion			SEQ #		

Date: ☐☐/☐☐/☐☐☐☐ (Month / Day / Year) Day: **0**

Instructions: Please complete this log *EACH MORNING* within one hour after you wake up.

What should I do if I miss a day? *If you forget to fill in the diary, leave the diary blank for that day.*

What do the words "bed", "day" and "night" mean on the diary? *This diary can be used for people who are awake or asleep at unusual times. In the sleep diary, the word "day" is the time when you choose or are required to be awake and the word "night" is the main time you choose to sleep. The term "bed" means the place where you usually sleep.*

Will answering these questions about my sleep keep me awake? *You should not worry about giving exact times, and you should not watch the clock. Just give your best estimate.*

1. What time did you go to bed and try to fall asleep last night? ☐☐:☐☐ ☐ am ☐ pm

2. How much time did it take you to fall asleep? ☐ Hours ☐☐ Minutes

3. Did you wake up during the night? No 0 ☐ / Yes 1 ☐

   3a. If yes, how many times? ☐☐ times

4. What time did you get out of bed today? ☐☐:☐☐ ☐ am ☐ pm

5. Did you go to work or school yesterday? No 0 ☐ / Yes 1 ☐

6. During the day yesterday, did you take naps or fall asleep for more than 5 minutes? No 0 ☐ / Yes 1 ☐

   6a. If yes, at what times did these naps begin? ☐☐:☐☐ ☐ am ☐ pm
   ☐☐:☐☐ ☐ am ☐ pm
   ☐☐:☐☐ ☐ am ☐ pm

REMINDER: Press the buttons on either side of the ActiWatch whenever you try to go to sleep today and whenever you wake up from sleep.

Daily Sleep Log
HCHS/SOL Sleep Ancillary Study

ID NUMBER:										Form Code: DSE Version: A 09/15/10	Contact Occasion			SEQ #		

Date: ☐☐/☐☐/☐☐☐☐ (Month / Day / Year) Day: **1**

Instructions: Please complete this log *EACH MORNING* within one hour after you wake up.

1. What time did you go to bed and try to fall asleep last night? ☐☐:☐☐ ☐ am ☐ pm

2. How much time did it take you to fall asleep? ☐ Hours ☐☐ Minutes

3. Did you wake up during the night? No 0 ☐ Yes 1 ☐

   3a. If yes, how many times? ☐☐ times

4. What time did you get out of bed today? ☐☐:☐☐ ☐ am ☐ pm

5. Did you go to work or school yesterday? No 0 ☐ Yes 1 ☐

6. During the day yesterday, did you take naps or fall asleep for more than 5 minutes? No 0 ☐ Yes 1 ☐

   6a. If yes, at what times did these naps begin?
   ☐☐:☐☐ ☐ am ☐ pm
   ☐☐:☐☐ ☐ am ☐ pm
   ☐☐:☐☐ ☐ am ☐ pm

REMINDER: Press the buttons on either side of the ActiWatch whenever you try to go to sleep today and whenever you wake up from sleep.

Daily Sleep Log
HCHS/SOL Sleep Ancillary Study

ID NUMBER:										Form Code: DSE Version: A 09/15/10	Contact Occasion			SEQ #		

Date: ☐☐/☐☐/☐☐☐☐ (Month / Day / Year) Day: **2**

Instructions: Please complete this log *EACH MORNING* within one hour after you wake up.

1. What time did you go to bed and try to fall asleep last night? ☐☐:☐☐ ☐ am ☐ pm

2. How much time did it take you to fall asleep? ☐ Hours ☐☐ Minutes

3. Did you wake up during the night? No 0 ☐ Yes 1 ☐

   3a. If yes, how many times? ☐☐ times

4. What time did you get out of bed today? ☐☐:☐☐ ☐ am ☐ pm

5. Did you go to work or school yesterday? No 0 ☐ Yes 1 ☐

6. During the day yesterday, did you take naps or fall asleep for more than 5 minutes? No 0 ☐ Yes 1 ☐

   6a. If yes, at what times did these naps begin?
   ☐☐:☐☐ ☐ am ☐ pm
   ☐☐:☐☐ ☐ am ☐ pm
   ☐☐:☐☐ ☐ am ☐ pm

REMINDER: Press the buttons on either side of the ActiWatch whenever you try to go to sleep today and whenever you wake up from sleep.

Daily Sleep Log
HCHS/SOL Sleep Ancillary Study

ID NUMBER:										Form Code: DSE Version: A 09/15/10	Contact Occasion			SEQ #		

Date: ☐☐/☐☐/☐☐☐☐ (Month / Day / Year) Day: **3**

Instructions: Please complete this log *EACH MORNING* within one hour after you wake up.

1. What time did you go to bed and try to fall asleep last night? ☐☐:☐☐ ☐ am ☐ pm

2. How much time did it take you to fall asleep? ☐ Hours ☐☐ Minutes

3. Did you wake up during the night? No 0 ☐ Yes 1 ☐

   3a. If yes, how many times? ☐☐ times

4. What time did you get out of bed today? ☐☐:☐☐ ☐ am ☐ pm

5. Did you go to work or school yesterday? No 0 ☐ Yes 1 ☐

6. During the day yesterday, did you take naps or fall asleep for more than 5 minutes? No 0 ☐ Yes 1 ☐

   6a. If yes, at what times did these naps begin?
   ☐☐:☐☐ ☐ am ☐ pm
   ☐☐:☐☐ ☐ am ☐ pm
   ☐☐:☐☐ ☐ am ☐ pm

REMINDER: Press the buttons on either side of the ActiWatch whenever you try to go to sleep today and whenever you wake up from sleep.

Daily Sleep Log
HCHS/SOL Sleep Ancillary Study

ID NUMBER:										Form Code: DSE Version: A 09/15/10	Contact Occasion			SEQ #		

Date: ☐☐/☐☐/☐☐☐☐ (Month / Day / Year) Day: **4**

Instructions: Please complete this log *EACH MORNING* within one hour after you wake up.

1. What time did you go to bed and try to fall asleep last night? ☐☐:☐☐ ☐ am ☐ pm

2. How much time did it take you to fall asleep? ☐ Hours ☐☐ Minutes

3. Did you wake up during the night? No 0 ☐ Yes 1 ☐

   3a. If yes, how many times? ☐☐ times

4. What time did you get out of bed today? ☐☐:☐☐ ☐ am ☐ pm

5. Did you go to work or school yesterday? No 0 ☐ Yes 1 ☐

6. During the day yesterday, did you take naps or fall asleep for more than 5 minutes? No 0 ☐ Yes 1 ☐

   6a. If yes, at what times did these naps begin?
   ☐☐:☐☐ ☐ am ☐ pm
   ☐☐:☐☐ ☐ am ☐ pm
   ☐☐:☐☐ ☐ am ☐ pm

REMINDER: Press the buttons on either side of the ActiWatch whenever you try to go to sleep today and whenever you wake up from sleep.

Daily Sleep Log
HCHS/SOL Sleep Ancillary Study

ID NUMBER:										Form Code: DSE Version: A 09/15/10	Contact Occasion			SEQ #		

Date: ☐☐/☐☐/☐☐☐☐ (Month / Day / Year) Day: **5**

Instructions: Please complete this log *EACH MORNING* within one hour after you wake up.

1. What time did you go to bed and try to fall asleep last night? ☐☐:☐☐ ☐ am ☐ pm

2. How much time did it take you to fall asleep? ☐ Hours ☐☐ Minutes

3. Did you wake up during the night? No 0 ☐ Yes 1 ☐

   3a. If yes, how many times? ☐☐ times

4. What time did you get out of bed today? ☐☐:☐☐ ☐ am ☐ pm

5. Did you go to work or school yesterday? No 0 ☐ Yes 1 ☐

6. During the day yesterday, did you take naps or fall asleep for more than 5 minutes? No 0 ☐ Yes 1 ☐

   6a. If yes, at what times did these naps begin?
   ☐☐:☐☐ ☐ am ☐ pm
   ☐☐:☐☐ ☐ am ☐ pm
   ☐☐:☐☐ ☐ am ☐ pm

REMINDER: Press the buttons on either side of the ActiWatch whenever you try to go to sleep today and whenever you wake up from sleep.

Daily Sleep Log
HCHS/SOL Sleep Ancillary Study

ID NUMBER:										Form Code: DSE Version: A 09/15/10	Contact Occasion			SEQ #		

Date: ☐☐/☐☐/☐☐☐☐ (Month / Day / Year)

Day: **6**

Instructions: Please complete this log *EACH MORNING* within one hour after you wake up.

1. What time did you go to bed and try to fall asleep last night? ☐☐:☐☐ ☐ am ☐ pm

2. How much time did it take you to fall asleep? ☐ Hours ☐☐ Minutes

3. Did you wake up during the night? No 0 ☐ Yes 1 ☐

   3a. If yes, how many times? ☐☐ times

4. What time did you get out of bed today? ☐☐:☐☐ ☐ am ☐ pm

5. Did you go to work or school yesterday? No 0 ☐ Yes 1 ☐

6. During the day yesterday, did you take naps or fall asleep for more than 5 minutes? No 0 ☐ Yes 1 ☐

   6a. If yes, at what times did these naps begin?
   ☐☐:☐☐ ☐ am ☐ pm
   ☐☐:☐☐ ☐ am ☐ pm
   ☐☐:☐☐ ☐ am ☐ pm

REMINDER: Press the buttons on either side of the ActiWatch whenever you try to go to sleep today and whenever you wake up from sleep.

Daily Sleep Log
HCHS/SOL Sleep Ancillary Study

ID NUMBER:										Form Code: DSE Version: A 09/15/10	Contact Occasion			SEQ #		

Date: ☐☐/☐☐/☐☐☐☐ (Month / Day / Year) Day: 7

Instructions: Please complete this log *EACH MORNING* within one hour after you wake up.

1. What time did you go to bed and try to fall asleep last night? ☐☐:☐☐ ☐ am ☐ pm

2. How much time did it take you to fall asleep? ☐ Hours ☐☐ Minutes

3. Did you wake up during the night? No 0 ☐ Yes 1 ☐

   3a. If yes, how many times? ☐☐ times

4. What time did you get out of bed today? ☐☐:☐☐ ☐ am ☐ pm

5. Did you go to work or school yesterday? No 0 ☐ Yes 1 ☐

6. During the day yesterday, did you take naps or fall asleep for more than 5 minutes? No 0 ☐ Yes 1 ☐

   6a. If yes, at what times did these naps begin? ☐☐:☐☐ ☐ am ☐ pm
   ☐☐:☐☐ ☐ am ☐ pm
   ☐☐:☐☐ ☐ am ☐ pm

REMINDER: Press the buttons on either side of the ActiWatch whenever you try to go to sleep today and whenever you wake up from sleep.

INSTRUCCIONES DEL ACTIWATCH

Sobre el ActiWatch

¿Qué está haciendo?

Aunque parezca un reloj, el ActiWatch es una máquina compleja y delicada. Adentro, tiene censores que registran cuándo y cómo el reloj se mueve que nos puede decir cuando está despierto y cuando está dormido. También tiene un detector de luz que nos dice a cuanta luz usted está expuesto. Usando el ActiWatch nos dejara saber sobre la cantidad y calidad de su sueño.

Es muy importante que el ActiWatch sea cuidado apropiadamente. Por favor siga las instrucciones en esta página y las que le dará el personal.

Usando el ActiWatch

- Por la próxima semana, **use el ActiWatch todo lo posible, por favor.**
- **El ActiWatch es a prueba de agua** – se puede usar en la ducha y mientras esté nadando.
- Use el ActiWatch en la mano con la cual no escribe (si escribe con la mano derecha, use el reloj en su mano izquierda)
- Trate el ActiWatch como un reloj caro. **Si tiene que quitárselo, por favor guárdelo en un lugar seguro.**
- Hay un censor de luz en el ActiWatch, entonces por favor manténgalo descubierto (de ropa, etc.) todo lo posible.
- Hay un botón en cada lado del ActiWatch. **Por favor oprima los dos botones durante 3 segundos para marcar cuando se va a ir a dormir y cuando se levanta.**

Preguntas o Problemas

Si tiene alguna pregunta o algún problema, llame a _____al (_ _ _) _ _ _ - _ _ _ _.

Daily Sleep Log
Sueño – Sleep Habits in HCHS_Spanish

ID NUMBER:										Form Code: DSS Version: A 10/11/10	Contact Occasion			SEQ #		

Fecha: ☐☐/☐☐/☐☐☐☐ (Month / Day / Year) Día: 0

Instrucciones: Por favor complete este cuestionario *CADA MAÑANA* dentro de una hora después que se levante.

¿Qué debo hacer si me olvido de un día? *Si se le olvida llenar el diario, déjelo en blanco por ese día.*

¿Qué quieren decir las palabras "cama", "día" y "noche" en el diario? *Este diario puede ser usado por personas que están despiertos o dormidos durante horas irregulares. En el diario de sueño, la palabra "día" es la hora que escoge o que tiene que estar despierto y la palabra "noche" es la hora principal que escoge dormirse. La palabra "cama" se refiere al lugar donde usualmente duerme.*

¿Responder estas preguntas sobre mi sueño me mantendrá despierto? *No debe preocuparse por dar la hora exacta, y no debe mirar el reloj. Simplemente estime la hora lo mejor que pueda.*

1. ¿A qué hora se acostó y trató de dormirse anoche? ☐☐:☐☐ ☐ am ☐ pm

2. ¿Cuánto tiempo le tomó dormirse? ☐ Horas ☐☐ Minutos

3. ¿Se levantó durante la noche? No 0 ☐ / Sí 1 ☐

   3a. Si es así, ¿cuántas veces? ☐☐ veces

4. ¿A qué hora se levantó de la cama hoy? ☐☐:☐☐ ☐ am ☐ pm

5. ¿Fue al trabajo o a la escuela ayer? No 0 ☐ / Sí 1 ☐

6. Durante el día de ayer, ¿tomó alguna siesta o se durmió más de 5 minutos? No 0 ☐ / Sí 1 ☐

   6a. Si es así, ¿a qué hora comenzaron las siestas? ☐☐:☐☐ ☐ am ☐ pm
   ☐☐:☐☐ ☐ am ☐ pm
   ☐☐:☐☐ ☐ am ☐ pm

RECUERDO: Oprima los botones en cada lado del ActiWatch cuando sea que trate de irse a dormir hoy y cuando se levante de su sueño.

Daily Sleep Log
Sueño – Sleep Habits in HCHS

ID NUMBER:										Form Code: DSS Version: 10/11/10	Contact Occasion			SEQ #		

Fecha: ☐☐/☐☐/☐☐☐☐ (Month / Day / Year) Día: 1

Instrucciones: Por favor complete este cuestionario *CADA MAÑANA* dentro de una hora después que se levante.

1. ¿A qué hora se acostó y trató de dormirse anoche? ☐☐:☐☐ ☐ am ☐ pm

2. ¿Cuánto tiempo le tomó dormirse? ☐ Horas ☐☐ Minutos

3. ¿Se levantó durante la noche? No 0 ☐ Sí 1 ☐

   3a. Si es así, ¿cuántas veces? ☐☐ veces

4. ¿A qué hora se levantó de la cama hoy? ☐☐:☐☐ ☐ am ☐ pm

5. ¿Fue al trabajo o a la escuela ayer? No 0 ☐ Sí 1 ☐

6. Durante el día de ayer, ¿tomó alguna siesta o se durmió más de 5 minutos? No 0 ☐ Sí 1 ☐

   6a. Si es así, ¿a qué hora comenzaron las siestas? ☐☐:☐☐ ☐ am ☐ pm
   ☐☐:☐☐ ☐ am ☐ pm
   ☐☐:☐☐ ☐ am ☐ pm

RECUERDO: Oprima los botones en cada lado del ActiWatch cuando sea que trate de irse a dormir hoy y cuando se levante de su sueño.

Daily Sleep Log
Sueño – Sleep Habits in HCHS

ID NUMBER:										Form Code: DSS Version: 10/11/10	Contact Occasion			SEQ #		

Fecha: ☐☐/☐☐/☐☐☐☐ (Month / Day / Year) Día: 2

Instrucciones: Por favor complete este cuestionario *CADA MAÑANA* dentro de una hora después que se levante.

1. ¿A qué hora se acostó y trató de dormirse anoche? ☐☐:☐☐ ☐ am ☐ pm

2. ¿Cuánto tiempo le tomó dormirse? ☐ Horas ☐☐ Minutos

3. ¿Se levantó durante la noche? No 0 ☐ Sí 1 ☐

   3a. Si es así, ¿cuántas veces? ☐☐ veces

4. ¿A qué hora se levantó de la cama hoy? ☐☐:☐☐ ☐ am ☐ pm

5. ¿Fue al trabajo o a la escuela ayer? No 0 ☐ Sí 1 ☐

6. Durante el día de ayer, ¿tomó alguna siesta o se durmió más de 5 minutos? No 0 ☐ Sí 1 ☐

   6a. Si es así, ¿a qué hora comenzaron las siestas? ☐☐:☐☐ ☐ am ☐ pm
   ☐☐:☐☐ ☐ am ☐ pm
   ☐☐:☐☐ ☐ am ☐ pm

RECUERDO: Oprima los botones en cada lado del ActiWatch cuando sea que trate de irse a dormir hoy y cuando se levante de su sueño.

Daily Sleep Log
Sueño – Sleep Habits in HCHS

ID NUMBER:										Form Code: DSS Version: 10/11/10	Contact Occasion			SEQ #		

Fecha: ☐☐/☐☐/☐☐☐☐
Month Day Year

Día: 3

Instrucciones: Por favor complete este cuestionario *CADA MAÑANA* dentro de una hora después que se levante.

1. ¿A qué hora se acostó y trató de dormirse anoche? ☐☐:☐☐ ☐ am ☐ pm

2. ¿Cuánto tiempo le tomó dormirse? ☐ Horas ☐☐ Minutos

3. ¿Se levantó durante la noche? No 0 ☐
   Sí 1 ☐

   3a. Si es así, ¿cuántas veces? ☐☐ veces

4. ¿A qué hora se levantó de la cama hoy? ☐☐:☐☐ ☐ am ☐ pm

5. ¿Fue al trabajo o a la escuela ayer? No 0 ☐
   Sí 1 ☐

6. Durante el día de ayer, ¿tomó alguna siesta o se durmió más de 5 minutos? No 0 ☐
   Sí 1 ☐

   6a. Si es así, ¿a qué hora comenzaron las siestas? ☐☐:☐☐ ☐ am ☐ pm
   ☐☐:☐☐ ☐ am ☐ pm
   ☐☐:☐☐ ☐ am ☐ pm

RECUERDO: Oprima los botones en cada lado del ActiWatch cuando sea que trate de irse a dormir hoy y cuando se levante de su sueño.

Daily Sleep Log
Sueño – Sleep Habits in HCHS

ID NUMBER:										Form Code: DSS Version: 10/11/10	Contact Occasion			SEQ #		

Fecha: ☐☐/☐☐/☐☐☐☐
Month Day Year

Día: 4

Instrucciones: Por favor complete este cuestionario *CADA MAÑANA* dentro de una hora después que se levante.

1. ¿A qué hora se acostó y trató de dormirse anoche? ☐☐:☐☐ ☐ am ☐ pm

2. ¿Cuánto tiempo le tomó dormirse? ☐ Horas ☐☐ Minutos

3. ¿Se levantó durante la noche? No 0 ☐
Sí 1 ☐

3a. Si es así, ¿cuántas veces? ☐☐ veces

4. ¿A qué hora se levantó de la cama hoy? ☐☐:☐☐ ☐ am ☐ pm

5. ¿Fue al trabajo o a la escuela ayer? No 0 ☐
Sí 1 ☐

6. Durante el día de ayer, ¿tomó alguna siesta o se durmió más de 5 minutos? No 0 ☐
Sí 1 ☐

6a. Si es así, ¿a qué hora comenzaron las siestas? ☐☐:☐☐ ☐ am ☐ pm
☐☐:☐☐ ☐ am ☐ pm
☐☐:☐☐ ☐ am ☐ pm

RECUERDO: Oprima los botones en cada lado del ActiWatch cuando sea que trate de irse a dormir hoy y cuando se levante de su sueño.

Daily Sleep Log
Sueño – Sleep Habits in HCHS

ID NUMBER:										Form Code: DSS Version: 10/11/10	Contact Occasion			SEQ #		

Fecha: ☐☐/☐☐/☐☐☐☐ (Month / Day / Year) Día: 5

Instrucciones: Por favor complete este cuestionario *CADA MAÑANA* dentro de una hora después que se levante.

1. ¿A qué hora se acostó y trató de dormirse anoche? ☐☐:☐☐ ☐ am ☐ pm

2. ¿Cuánto tiempo le tomó dormirse? ☐ Horas ☐☐ Minutos

3. ¿Se levantó durante la noche? No 0 ☐ Sí 1 ☐

   3a. Si es así, ¿cuántas veces? ☐☐ veces

4. ¿A qué hora se levantó de la cama hoy? ☐☐:☐☐ ☐ am ☐ pm

5. ¿Fue al trabajo o a la escuela ayer? No 0 ☐ Sí 1 ☐

6. Durante el día de ayer, ¿tomó alguna siesta o se durmió más de 5 minutos? No 0 ☐ Sí 1 ☐

   6a. Si es así, ¿a qué hora comenzaron las siestas? ☐☐:☐☐ ☐ am ☐ pm
   ☐☐:☐☐ ☐ am ☐ pm
   ☐☐:☐☐ ☐ am ☐ pm

RECUERDO: Oprima los botones en cada lado del ActiWatch cuando sea que trate de irse a dormir hoy y cuando se levante de su sueño.

Daily Sleep Log
Sueño – Sleep Habits in HCHS

ID NUMBER:										Form Code: DSS Version: 10/11/10	Contact Occasion			SEQ #		

Fecha: ☐☐/☐☐/☐☐☐☐ (Month / Day / Year)

Día: 6

Instrucciones: Por favor complete este cuestionario *CADA MAÑANA* dentro de una hora después que se levante.

1. ¿A qué hora se acostó y trató de dormirse anoche? ☐☐:☐☐ ☐ am ☐ pm

2. ¿Cuánto tiempo le tomó dormirse? ☐ Horas ☐☐ Minutos

3. ¿Se levantó durante la noche? No 0 ☐ Sí 1 ☐

   3a. Si es así, ¿cuántas veces? ☐☐ veces

4. ¿A qué hora se levantó de la cama hoy? ☐☐:☐☐ ☐ am ☐ pm

5. ¿Fue al trabajo o a la escuela ayer? No 0 ☐ Sí 1 ☐

6. Durante el día de ayer, ¿tomó alguna siesta o se durmió más de 5 minutos? No 0 ☐ Sí 1 ☐

   6a. Si es así, ¿a qué hora comenzaron las siestas? ☐☐:☐☐ ☐ am ☐ pm
   ☐☐:☐☐ ☐ am ☐ pm
   ☐☐:☐☐ ☐ am ☐ pm

RECUERDO: Oprima los botones en cada lado del ActiWatch cuando sea que trate de irse a dormir hoy y cuando se levante de su sueño.

Daily Sleep Log
Sueño – Sleep Habits in HCHS

ID NUMBER:										Form Code: DSS Version:10/11/10	Contact Occasion			SEQ #		

Fecha: ☐☐/☐☐/☐☐☐☐ (Month / Day / Year) Día: 7

Instrucciones: Por favor complete este cuestionario *CADA MAÑANA* dentro de una hora después que se levante.

1. ¿A qué hora se acostó y trató de dormirse anoche? ☐☐:☐☐ ☐ am ☐ pm

2. ¿Cuánto tiempo le tomó dormirse? ☐ Horas ☐☐ Minutos

3. ¿Se levantó durante la noche? No 0 ☐ Sí 1 ☐

   3a. Si es así, ¿cuántas veces? ☐☐ veces

4. ¿A qué hora se levantó de la cama hoy? ☐☐:☐☐ ☐ am ☐ pm

5. ¿Fue al trabajo o a la escuela ayer? No 0 ☐ Sí 1 ☐

6. Durante el día de ayer, ¿tomó alguna siesta o se durmió más de 5 minutos? No 0 ☐ Sí 1 ☐

   6a. Si es así, ¿a qué hora comenzaron las siestas? ☐☐:☐☐ ☐ am ☐ pm
   ☐☐:☐☐ ☐ am ☐ pm
   ☐☐:☐☐ ☐ am ☐ pm

RECUERDO: Oprima los botones en cada lado del ActiWatch cuando sea que trate de irse a dormir hoy y cuando se levante de su sueño.

Sueño Actigraph Watch Log

Site:_____

Study ID	Serial Number	Date Given	Date Sender to Return	Date Actually Returned	Download and Reviewed	Number of Days of Valid Data	Is it Greater Than Five Days?	If not, Reason for Incomplete Data	Was Study Repeated?	Any Download Errors	Was Raw Data and Sleep Log Sent to Reading Center	Date Sent to Reading Center

Study Failure Form
HCHS/SOL Sueño Study

To be completed by Reading Center Staff:

Date Failed (MM/DD/YY): ☐☐/☐☐/☐☐
ID Number: ☐☐☐☐☐☐☐☐
Staff Initials: ☐☐☐
Contact Occasion: ☐

Failure Reason:
- ○ Fewer than 5 days of valid data
- ○ Data corruption/ technical failure
- ○ Other (*specify in notes below)*

Notes:

To be completed by Field Site Staff:

Date Contacted Participant (MM/DD/YY): ☐☐/☐☐/☐☐
Staff Number: ☐☐☐

Participant Status:
- ○ Willing to Repeat Study
- ○ Unwilling to Repeat Study
- ○ Unable to Contact
- ○ Other (*specify in notes below)*

Notes:

Important: *Submit completed form to the Reading Center*

Appendix VI – Summary letter.....132

A. Summary Letter – English.....133
B. Summary Letter – Spanish.....135

<Letterhead>
SUEÑO – Sleep Ancillary to the Hispanic Community Health Study/Study of Latinos

<Date>
<Name>
<Address>

Dear <Name>,

Thank you for your participation in the Sueño study – an ancillary study to the Hispanic Community Health Study – Study of Latinos. The results from the actigraph that you wore suggest that on average during your main sleep period, you obtain <___> hours of sleep and are awake for <___> hours.

On the back of this letter, please find general tips about healthy sleep habits. In general, most people feel their best if they get 7-8 hours of sleep per night. However, this can vary a lot from person to person. If you think you are not sleeping as well as you should, you feel tired during the day, or have trouble getting to sleep, you should talk to your doctor.

Once again, thank you for your involvement with this study. We hope it will help us learn more about the sleep patterns in Hispanic-Americans/Latinos and how sleep might be important for overall health.

Sincerely,

[Name of local PI]

[Field Center name]

SUEÑO – Sleep Ancillary to the Hispanic Community Health Study/Study of Latinos

Ten Healthy Sleep Tips

1. Maintain a regular bed time and wake time schedule including on weekends.

2. Establish a regular, relaxing bedtime routine such as soaking in a hot bath and then reading a book or listening to soothing music.

3. Create an environment that encourages sleep by making sure the place you sleep is dark, quiet, comfortable and cool.

4. Sleep on a comfortable mattress and pillows.

5. Avoid watching television, using the computer or doing work in your bedroom.

6. Finish eating at least 2-3 hours before your regular bedtime.

7. Exercise regularly. It is best to complete your workout at least a few hours before bedtime.

8. Avoid drinks that contain caffeine (coffee, tea, soft drinks) close to bedtime. They can keep you awake.

9. Avoid products that contain nicotine (cigarettes). Used close to bedtime, they can lead to poor quality sleep.

10. Avoid alcohol close to bedtime.

<Letterhead>
SUEÑO – Sleep Ancillary to the Hispanic Community Health Study-Study of Latinos

<Date>
<Name>
<Address>

Dear <Name>,

Gracias por su participación en el estudio Sueño – un estudio auxiliar del Estudio Sobre Salud de la Comunidad Hispana/Estudio de Latinos. Los resultados del actígrafo que usó sugieren que durante el período principal de sueño, usted obtiene en promedio <___> horas de sueño, y está <___> horas despierto.

Atrás de esta página, por favor vea los consejos generales sobre los hábitos de dormir saludables. En general, la mayoría de personas se sienten mejor si duermen 7-8 horas cada noche. Sin embargo, esto puede variar mucho de persona a persona. Si usted piensa que no está durmiendo como debería, se siente cansado durante el día, o tiene problemas para dormirse, debe hablar con su doctor.

Una vez más, gracias por su participación en este estudio. Esperamos que nos ayude aprender más sobre los hábitos de dormir en los hispano-americanos y como el dormir puede ser importante para la salud en general.

Sinceramente,

[Name of local PI]

[Field Center name]

SUEÑO – Sleep Ancillary to the Hispanic Community Health Study – Study of Latinos

Diez Consejos para el Sueño Saludable

1. **Mantener una hora consistente para acostarse y levantarse, incluyendo los fines de semana.**
2. **Establecer una rutina de dormir y relajada como un baño caliente y después leer un libro o escuchar música calmante.**
3. **Crear un medioambiente que fomente el sueño, asegurándose que el lugar en donde duerma sea oscuro, silencioso, cómodo, y fresco.**
4. **Dormir en un colchón cómodo y con almohadas cómodas.**
5. **Evitar ver la televisión, usar la computadora, o trabajar en su habitación.**
6. **Terminar de comer por lo menos 2 ó 3 horas antes de su hora de la hora habitual en la que se acuesta.**
7. **Hacer ejercicio regularmente. Es mejor hacer ejercicio por lo menos un par de horas antes de la hora de dormir.**
8. **Evitar bebidas que contengan cafeína (café, té, refrescos) cerca de la hora de dormir. Pueden mantenerlo/la despierto/a.**
9. **Evitar productos que contengan nicotina (cigarrillos). Si se consumen cerca de la hora de acostarse, pueden causar mala calidad del sueño.**
10. **Evitar el alcohol cerca de la hora de acostarse.**

Appendix VII – Sueño Unanticipated Adverse Event form……..……..……137

Sueño Unanticipated Adverse Event Form

ID Number: ☐☐☐☐☐☐☐☐ Contact Occasion: ☐

Instructions: *This form should be completed* ***within a week*** *if the Principal Investigator at your site determines the AE constitutes an unanticipated adverse event (UAE).*

Form Completion Date: ☐☐/☐☐/☐☐ Staff ID: ☐☐☐

Principal Investigator: ☐ Field Center: ☐

Date AE Occurred: ☐☐/☐☐/☐☐

Date Field Center Became Aware: ☐☐/☐☐/☐☐

Indicate whether the event is: ☐ Ongoing ☐ Resolved

Is this type of event foreseen in the Informed Consent or study MOP?

☐ Yes ☐ No ☐ Don't know

Likelihood of Relationship to Participation in Sueño:

- ☐ Definitely related
- ☐ Possibly related
- ☐ Not related

Severity of the Event:

- ☐ Mild
- ☐ Moderate
- ☐ Severe

Describe the Event:

Describe What Action was Taken: