

Postal survey items

On a “typical” night during the past month...

1. What time did you usually turn off the lights and try to go to sleep for the night?
2. How many minutes did it usually take you to fall asleep each night?
3. What time did you usually get out of bed in the morning to start your day?
4. How many hours of actual sleep did you usually get during the night?

On a “typical” night during the past month did you ...

- | | | |
|--|-----|----|
| 5. Have trouble falling asleep? | YES | NO |
| 6. Have trouble staying asleep all night? | YES | NO |
| 7. Wake up earlier than you wanted? | YES | NO |
| 8. Have a comfortable place to sleep? | YES | NO |
| 9. Take a prescription medication to help you sleep? | YES | NO |
| 10. Take an over-the-counter medication to help you sleep? | YES | NO |

During the past month, did you have any of the following symptoms because you did not sleep well at night?

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|--|-----|----|
| 11. Feel tired or fatigued during the day? | YES | NO |
| 12. Have trouble paying attention, concentrating, or remembering things? | YES | NO |
| 13. Have difficulty with work or social life? | YES | NO |
| 14. Feel irritable, depressed or anxious? | YES | NO |
| 15. Feel sleepy during the day? | YES | NO |
| 16. Have less motivation, energy, or drive? | YES | NO |
| 17. Make mistakes or have accidents? | YES | NO |
| 18. Feel achy, have headaches or stomach problems? | YES | NO |
| 19. Worry about your sleep? | YES | NO |
| 20. Take a nap or doze off during the daytime? | YES | NO |
| 21. In general, how would you describe your sleep during the past month? | | |
| a. Very good | | |
| b. Fairly good | | |
| c. Fairly bad | | |
| d. Very bad | | |
| 22. How long have you had problems with your sleep? | | |
| a. Less than 3 months | | |
| b. 3 months to 12 months | | |
| c. More than 12 months | | |
| d. I don't have sleep problems | | |
| 23. Have you ever talked to a doctor about sleep problems? | YES | NO |