Draft

Sleep Habits

Office Use Only--
MrOS ID#

Acrostic

○ MISSING
Staff ID# PQSTAFF

Questions 1 - 5 relate to your usual sleep habits during the past month only. Your answers should indicate the most accurate reply for the majority of days and nights in the past month. PQPTMBED

1. **During the past month, what time have you usually gone to bed at night?** ___ : ___ ○ A.M. ○ P.M.
2. **During the past month, how long (in minutes) has it usually taken you to fall asleep each night?** PQPSLPM ___ minutes PQPSLDUR PQPINBED PQPSLPM4
3. **During the past month, when have you usually gotten up in the morning?** ___ : ___ ○ A.M. ○ P.M.
4. **During the past month, how many hours of actual sleep did you get each night? (This may be different than the number of hours you spent in bed.)** PQPACTSL ___ hours PQPTMWAK PQPEFFCY PQPEFFIC

For questions 5-9, mark the one best response. Please answer all questions.

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

PQPLATEN PQDISTUR PQBADSLP PQDAYDYS PQPSQI

	Not During the Past Month	Less than Once a Week	Once or Twice a Week	Three or More Times a Week
a. Cannot get to sleep within 30 minutes PQP30M	0 ○	1 ○	2 ○	3 ○
b. Wake up in middle of the night or early morning PQPWAKE	○	○	○	○
c. Have to get up to use the bathroom PQPBATH	○	○	○	○
d. Cannot breathe comfortably PQPBREA	○	○	○	○
e. Cough or snore loudly PQPSNOR	○	○	○	○
f. Feel too cold PQPCOLD	○	○	○	○
g. Feel too hot PQPHOT	○	○	○	○
h. Have bad dreams PQPBAD	○	○	○	○
i. Have pain PQPPAIN	○	○	○	○
j. Have leg jerks or leg cramps SLJERK	○	○	○	○
k. Have heartburn SLHBURN	○	○	○	○
l. Other reasons Describe: PQPOTH	○	○	○	○

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For questions 6 - 9, mark the one best response. Please answer all questions.

	Not During the Past Month	Less than Once a Week	Once or Twice a Week	Three or More Times a Week
6 During the past month, how often have you taken medicine (prescribed or "over the counter") to help you sleep? PQPSLMED	0 ○	1 ○	2 ○	3 ○
7 During the past month, how often have you had trouble staying awake while driving, eating meals, or engaging in social activity? PQPTRBSA	0 ○	1 ○	2 ○	3 ○

8 During the past month, how would you rate your sleep quality overall? PQPSQUAL

0 ○ Very good 1 ○ Fairly good 2 ○ Fairly bad 3 ○ Very bad

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

0 ○ No problem at all 1 ○ Only a slight problem 2 ○ Somewhat of a problem 3 ○ A very big problem

10 Do you have a bed partner or roommate? (including spouse) 1 ○ Yes 0 ○ No PQBEDPAR

↓

Please describe your bed partner or roommate: PQBPTYPE

1 ○ Partner or Roommate in SAME bed
2 ○ Partner in SAME room but NOT SAME bed
3 ○ Partner or Roommate in OTHER room

Please ask your bed partner or roommate how often in the past month you have had...	Not During the Past Month	Less than Once a Week	Once or Twice a Week	Three or More Times a Week
a. Loud snoring PQBPLOUD	0 ○	1 ○	2 ○	3 ○
b. Long pauses between breaths while asleep PQBPPAUS	0 ○	1 ○	2 ○	3 ○
c. Legs twitching or jerking while you sleep PQBPLEGS	0 ○	1 ○	2 ○	3 ○
d. Episodes of disorientation or confusion during sleep PQBPCONF	0 ○	1 ○	2 ○	3 ○
e. Other restlessness while you sleep: Please describe: PQBPOTH _____	0 ○	1 ○	2 ○	3 ○

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1 Have you ever snored (now or at anytime in the past)? 1○ Yes 0○ No 8○ Don't know SLSNORE

How often do you snore now? SLOFTSNO

0○ Do not snore anymore
1○ Rarely (less than 1 night a week)
2○ Sometimes (1 or 2 nights a week)
3○ Frequently (3 to 5 nights a week)
4○ Always or almost always (6 or 7 nights a week)
8○ Don't know

2 Are there times when you stop breathing during your sleep?

1○ Yes 0○ No 8○ Don't know SLSTOPBR

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

1○ Rarely (less than one night a week)
2○ Sometimes (1 or 2 nights a week)
3○ Frequently (3 to 5 nights a week)
4○ Always or almost always (6 or 7 nights a week)
8○ Don't know

3 Has a doctor or health care provider ever told you that you have sleep apnea (a condition in which breathing stops briefly during sleep)? SLSA

1○ Yes 0○ No 8○ Don't know

a. Do you sleep with either a pressure mask ("CPAP") or a mouthpiece as treatment for your sleep apnea? 1○ Yes 0○ No SLSCAP

b. Have you had surgery as treatment for your sleep apnea? 1○ Yes 0○ No SLSSURG

4 Has a doctor or health care provider ever told you that you have a sleep disorder other than sleep apnea?

1○ Yes 0○ No 8○ Don't know SLSLPDIS

What other sleep disorder? Check all that apply.

○ Insomnia 1 SLINSOM
○ Restless legs 1 SLRESTL
○ Periodic leg movements 1 SLPERLEG
○ Narcolepsy 1 SLNARC
○ Other → Please describe: _____ 1 SLSDOTH

5 Over the past month, how many times did you most typically get up to urinate from the time you went to bed at night until the time you got up in the morning?

0○ None 1○ 1 time 2○ 2 times 3○ 3 times 4○ 4 times 5○ 5 times or more PSUP

6 Do you ever drink alcohol to help you sleep? 1○ Yes 0○ No 8○ Don't know SLSLALC

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MrOS Sleep Visit 2

Mr. OS Sleep

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Medical History

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7 **Do you usually use oxygen therapy (oxygen delivered by a tube or face mask)?**
1 ○ Yes 0 ○ No 8 ○ Don't Know SLOXTHER

a. Do you use it during sleep? 1 ○ Yes 0 ○ No SLOXSLP

How often do you use it during sleep? SLOXSLPO
1 ○ Rarely (less than one night a week) 4 ○ Always or almost always (6 or 7 nights a week)
2 ○ Sometimes (1 or 2 nights a week) 8 ○ Don't know
3 ○ Frequently (3 to 5 nights a week)

b. Do you use it during wake? 1 ○ Yes 0 ○ No SLOXWAK

How often do you use it during wake? SLOXWAKO
1 ○ Rarely (less than one day a week) 4 ○ Always or almost always (6 or 7 days a week)
2 ○ Sometimes (1 or 2 days a week) 8 ○ Don't know
3 ○ Frequently (3 to 5 days a week)

8 **Do you awake from sleep at night due to pain?** 1 ○ Yes 0 ○ No 8 ○ Don't Know SLPAIN

a. Where is the pain located? (Mark all that apply)
○ Hip 1 SLPAINHP ○ Knee 1 SLPAINKN ○ Back 1 SLPAINBK ○ Other 1 SLPAINOT

b. Do you experience pain when you roll over from your back to your side during sleep?
1 ○ Yes 0 ○ No 8 ○ Don't Know SLPAINRL

9 **During the <u>past 12 months</u>, have you fallen and landed on the floor or ground, or fallen and hit an object like a table or chair?** 1 ○ Yes 0 ○ No MHFALL

a. How many times have you fallen in the past 12 months? 1 ○ 1 2 ○ 2-3 3 ○ 4-5 4 ○ 6 or more MHFALLTM

b. Which of the following injuries did you have? (Mark all that apply)
1 MHFRACT ○ I broke or fractured a bone
1 MHHEAD ○ I hit or injured my head
○ I had a sprain or a strain 1 MHSPRAIN
1 MHBRUISE ○ I had a bruise or bleeding
1 MHOTHER ○ I had some other kind of injury
1 MHNOINJR ○ I did not have any injuries from a fall in the past 12 months

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Medical History

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10 **During the past 12 months, have you been trying to lose weight?**

1 ○ Yes 0 ○ No MHWTLO

By what means were you trying to lose weight? (Mark all that apply)

1 MHWDIET ○ Diet

1 MHWPILL ○ Diet pills

○ Exercise 1 MHWEXE

○ Other 1 MHWOTH

Please specify: _____

11 **Has a doctor or other health care provider ever told you that you had:**

a. Diabetes?

1 ○ Yes 0 ○ No MHDIAB

Are you currently being treated for this by a doctor? 1 ○ Yes 0 ○ No MHDIABT

b. High thyroid, Graves disease or an overactive thyroid gland?

1 ○ Yes 0 ○ No MHHTHY

Are you currently being treated for this by a doctor? 1 ○ Yes 0 ○ No MHHTHYT

c. Low thyroid or an under active thyroid gland?

1 ○ Yes 0 ○ No MHLTHY

Are you currently being treated for this by a doctor? 1 ○ Yes 0 ○ No MHPROST

d. Rheumatoid arthritis?

1 ○ Yes 0 ○ No MHRHEU1

Are you currently being treated for this by a doctor? 1 ○ Yes 0 ○ No MHRHEUT

e. Osteoporosis, sometimes called thin or brittle bones?

1 ○ Yes 0 ○ No MHOSTEO

Are you currently being treated for this by a doctor? 1 ○ Yes 0 ○ No MHOSTEOT

f. Osteoarthritis or degenerative arthritis?

1 ○ Yes 0 ○ No MHOA

Are you currently being treated for this by a doctor? 1 ○ Yes 0 ○ No MHOAT

g. Prostatitis (inflammation or infection of the prostate)?

1 ○ Yes 0 ○ No MHPROST

Are you currently being treated for this by a doctor? 1 ○ Yes 0 ○ No MHPROSTT

h. Parkinson's disease?

1 ○ Yes 0 ○ No MHPARK

Are you currently being treated for this by a doctor? 1 ○ Yes 0 ○ No MHPARKT

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11 Has a doctor or other health care provider ever told you that you had (continued):

i. Liver disease?
1○ Yes 0○ No MHLIVER

Are you currently being treated for this by a doctor? 1○ Yes 0○ No MHLIVERT

j. Chronic kidney (renal) disease or kidney (renal) failure?
1○ Yes 0○ No MHRENAL

Do you currently undergo dialysis? 1○ Yes 0○ No MHRENALT

k. Dementia or Alzheimer's disease?
1○ Yes 0○ No MHALZH

Are you currently being treated for this by a doctor? 1○ Yes 0○ No MHALZHT

l. Depression?
1○ Yes 0○ No MHDEPR

Are you currently being treated for this by a doctor? 1○ Yes 0○ No MHDEPRT

m. Asthma?
1○ Yes 0○ No MHASTHM

Are you currently being treated for this by a doctor? 1○ Yes 0○ No MHASTHMT

n. Hayfever or seasonal allergies?
1○ Yes 0○ No MHALLER

Are you currently being treated for this by a doctor? 1○ Yes 0○ No MHALLERT

o. Glaucoma?
1○ Yes 0○ No MHGLAU

Are you currently being treated for this by a doctor? 1○ Yes 0○ No MHGLAUT

p. Fibromyalgia ?
1○ Yes 0○ No FIBRO

Are you currently being treated for this by a doctor? 1○ Yes 0○ No MHFIBROT

12 Has a doctor or other health care provider ever told you that you have cataracts? 1○ Yes 0○ No MHCAT

Was this corrected? MHCATT
1○ Yes, left eye corrected 2○ Yes, right eye corrected 3○ Yes, both eyes corrected 0○ No 8○ Don't know

MHAFIB MHAFIBS
MHHR MHHHRS

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Cardiovascular History

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1 Has a doctor or other health care provider ever told you that you had:

a. Heart attack, coronary or myocardial infarction? 1○ Yes 0○ No MHMI

→ Are you currently being treated for this by a doctor? 1○ Yes 0○ No MHMIT

b. Angina (chest pain)? 1○ Yes 0○ No MHANGIN

→ Are you currently being treated for this by a doctor? 1○ Yes 0○ No MHANGINT

c. Congestive heart failure or enlarged heart? 1○ Yes 0○ No MHCHF

→ Are you currently being treated for this by a doctor? 1○ Yes 0○ No MHCHFT

d. Intermittent claudication or pain in your legs from a blockage of the arteries? 1○ Yes 0○ No CVBLKA

→ Are you currently being treated for this by a doctor? 1○ Yes 0○ No CVBLKAT

e. TIA, transient ischemic attack, or mini-stroke? 1○ Yes 0○ No CVTIA

→ Are you currently being treated for this by a doctor? 1○ Yes 0○ No CVTIAT

f. A stroke, blood clot in the brain or bleeding in the brain? 1○ Yes 0○ No MHSTRK

→ Are you currently being treated for this by a doctor? 1○ Yes 0○ No MHSTRKT

g. Rheumatic heart disease or valvular heart disease? 1○ Yes 0○ No CVRHD

→ Are you currently being treated for this by a doctor? 1○ Yes 0○ No CVRHDT

h. Hypertension or high blood pressure? 1○ Yes 0○ No MHBP

→ Are you currently being treated for this by a doctor? 1○ Yes 0○ No MHBPT

2 Have you ever had any medical or surgical procedure in your heart, neck or blood vessels, such as angioplasty or bypass surgery? 1○ Yes 0○ No 8○ Don't Know CVSURG

→

a. Coronary bypass surgery, heart bypass or CABG? CVCABG 1○ Yes 0○ No 8○ Don't Know

b. Angioplasty of coronary arteries, which is a dilation of arteries of the heart with a balloon? 1○ Yes 0○ No 8○ Don't Know CVAPCORA

c. Repair of aortic aneurysm? 1○ Yes 0○ No 8○ Don't Know CVAORANE

d. Bypass procedure on the arteries of your legs? 1○ Yes 0○ No 8○ Don't Know CVBPLEGS

e. Angioplasty of lower extremity arteries, which is dilation of arteries of the leg with a balloon? 1○ Yes 0○ No 8○ Don't Know CVAPLOW

f. Carotid endarterectomy, which is surgery on the blood vessels in your neck? 1○ Yes 0○ No 8○ Don't Know CVSURGBV

g. Pacemaker implant? CVPACE 1○ Yes 0○ No 8○ Don't Know

h. Replacement of a heart valve? CVVALVE 1○ Yes 0○ No 8○ Don't Know

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Cardiovascular History

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3 Have you ever had any pain or discomfort in your chest?

1 ○ Yes 0 ○ No 8 ○ Don't Know CVCHPAIN

0 → GO TO NEXT PAGE

a. Do you get it when you walk up a hill or hurry?

1 ○ Yes 0 ○ No 8 ○ Don't Know CVCPHILL

1. Do you get it when you walk at an ordinary pace on a level surface?

1 ○ Yes 0 ○ No 8 ○ Don't Know CVCPWALK

2. What do you do if you get it while you are walking?

1 ○ Stop or slow down 2 ○ Continue at same pace 8 ○ Don't Know CVCPDO

3. If you stand still, is the pain relieved or not relieved?

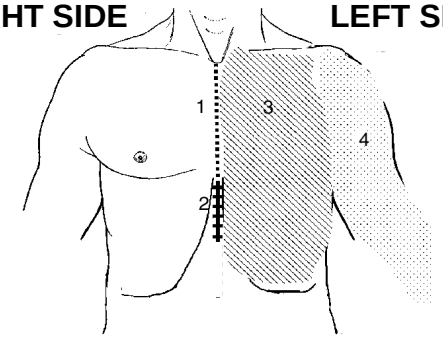
1 ○ Relieved 2 ○ Not relieved 8 ○ Don't Know CVCPREL

How soon is it relieved? CVCPRELT

1 ○ 10 minutes or less 2 ○ More than 10 minutes 8 ○ Don't Know

4. Where do you get this pain or discomfort? Mark any areas that apply with an X.

RIGHT SIDE **LEFT SIDE**



Clinic Use Only

○ SUM 1 CVLOCSUM
○ SL 1 CVLOCSL
○ LC 1 CVLOCLC
○ LA 1 CVLOCLA
○ OT 1 CVLOCOT
○ DK 1 CVLOCDK

b. Have you ever had a severe pain across the front of your chest lasting for half an hour or more?

1 ○ Yes 0 ○ No 8 ○ Don't Know CVCP30M

1. Did you see a doctor because of this pain?

1 ○ Yes 0 ○ No 8 ○ Don't Know CVCPDOC

What did your doctor say this was? CVCPDSAY

1 ○ Angina 2 ○ Heart attack 3 ○ Other 8 ○ Don't Know

Cardiovascular History

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4 **Do you get a pain or discomfort in your legs when you walk?**

1○ Yes 0○ No 8○ Don't Know *CVLGPAIN*

a. Does this pain ever begin when you are standing still or sitting?

1○ Yes 0○ No 8○ Don't Know *CVLPSTIL*

b. Do you get it if you walk uphill or hurry?

1○ Yes 0○ No 8○ Don't Know *CVLPHILL*

c. Do you get it when you walk at an ordinary pace on a level surface?

1○ Yes 0○ No 8○ Don't Know *CVLPWALK*

d. What happens if you stand still?

1○ Usually continues for more than 10 minutes
2○ Usually disappears in 10 minutes or less
8○ Don't Know

CVLPSTST

e. Do you get this pain in your calf (or calves)?

1○ Yes 0○ No 8○ Don't Know *CVLPCALF*

f. Were you hospitalized for this problem in your legs?

1○ Yes 0○ No 8○ Don't Know *CVLPHOSP*

5 **The following question is about the overall level of pain in your body at this moment. On the scale below, please mark the number that best describes any pain you may be experiencing:** *BHBDPAIN*

No Pain — **Worst Possible Pain**

0	1	2	3	4	5	6	7	8	9	10	11 Don't Know
○	○	○	○	○	○	○	○	○	○	○	○

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Respiratory Symptoms

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These questions are about respiratory or chest symptoms. Please answer Yes or No. If you are in doubt whether your answer is Yes or No, answer No.

1 **Do you usually have a cough? (Exclude clearing of throat.)**

1 ○ Yes 0 ○ No LFCOUGH

a. Do you usually cough as much as 4 times a day, 4 or more days out of the week? 1 ○ Yes 0 ○ No LFCOUGH4

b. How many years have you had this cough? ☐☐ years LFCOUGHY

2 **Do you usually bring up phlegm from your chest?**

1 ○ Yes 0 ○ No LFPHLEM

a. Do you usually bring up phlegm like this as much as twice a day, 4 or more days out of the week? 1 ○ Yes 0 ○ No LFPHLEM4

b. How many years have you had this trouble with phlegm? ☐☐ LFPHLEMY years

3 **Have you ever had wheezing or whistling in your chest?**

1 ○ Yes 0 ○ No LFCHWHZ

About how old were you when you first had a wheezing or whilsting in your chest?? ☐☐ years old LFCHWHZA ○ Don't Know 1 LFCHWHZD

4 **Have you ever had an attack of wheezing or whistling that made you feel short of breath?**

1 ○ Yes 0 ○ No LFWZATTK

a. About how old were you when you had your first such attack? ☐☐ years old LFWZAGE ○ Don't Know 1 LFWZAGED

b. Have you had two or more such attacks? 1 ○ Yes 0 ○ No 8 ○ Don't Know LFWZATK2

c. Have you ever required medicine or treatment for such attacks? 1 ○ Yes 0 ○ No 8 ○ Don't Know LFWZMED

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Respiratory Symptoms

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These questions are about respiratory or chest symptoms. Please answer Yes or No. If you are in doubt whether your answer is Yes or No, answer No.

5 **In the last 12 months, have you had wheezing or whistling in your chest at any time?**

1 ○ Yes 0 ○ No *LFCHWHEZ*

In the last 12 months, does your chest ever sound wheezy or whistling...

a. When you have a cold? 1 ○ Yes 0 ○ No *LFCHCOLD*

b. Occasionally apart from colds? 1 ○ Yes 0 ○ No *LFCHOCC*

c. More than once a week? 1 ○ Yes 0 ○ No *LFCH1WK*

d. Most days and nights? 1 ○ Yes 0 ○ No *LFCHMOST*

6 **In the last 12 months, have you been awakened from sleep by coughing, apart from a cough associated with a cold or chest infection?**

1 ○ Yes 0 ○ No *LFSLCOGH*

7 **In the last 12 months, have you been awakened from sleep by shortness of breath or a feeling of tightness in your chest?**

1 ○ Yes 0 ○ No *LFSLSHRT*

8 **Are you troubled by shortness of breath when hurrying on the level or walking up a slight hill?**

1 ○ Yes 0 ○ No *LFSBWALK*

a. Do you have to walk slower than people your age on level ground because of shortness of breath?

1 ○ Yes 0 ○ No 2 ○ Does not apply *LFSBSLOW*

b. Do you ever have to stop for breath when walking at your own pace on level ground?

1 ○ Yes 0 ○ No 2 ○ Does not apply *LFSBPACE*

c. Do you ever have to stop for breath after walking about 100 yards (or after a few minutes) on level ground?

1 ○ Yes 0 ○ No 2 ○ Does not apply *LFSB100Y*

d. Are you too short of breath to leave the house or short of breath on dressing or undressing?

1 ○ Yes 0 ○ No 2 ○ Does not apply *LFSBDRES*

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Respiratory Symptoms

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These questions are about respiratory or chest symptoms. Please answer Yes or No. If you are in doubt whether your answer is Yes or No, answer No.

9 **Have you ever had chronic bronchitis?**

1 ○ Yes 0 ○ No 8 ○ Don't know LFCBRONC

LFCBDIAG

a. Was it diagnosed by a doctor or other health professional? 1 ○ Yes 0 ○ No

b. At about what age did it start? ☐☐ years old ○ Don't Know LFCBAGE 1 LFCBAGED

c. Do you still have it? 1 ○ Yes 0 ○ No 8 ○ Don't Know LFCBHAVE

d. In the past 12 months, have you received medical treatment, taken medications or used an inhaler for chronic bronchitis? 1 ○ Yes 0 ○ No LFCBMED

10 **Have you ever had emphysema?**

1 ○ Yes 0 ○ No 8 ○ Don't know LFEMPHYS

a. Was it diagnosed by a doctor or other health professional? 1 ○ Yes 0 ○ No LFEMDIAG

b. At about what age did it start? ☐☐ years old ○ Don't Know LFEMAGE 1 LFEMAGED

c. Do you still have it? 1 ○ Yes 0 ○ No 8 ○ Don't Know LFEMHAVE

d. In the past 12 months, have you received medical treatment, taken medications or used an inhaler for emphysema? 1 ○ Yes 0 ○ No LFEMMED

11 **Have you ever had COPD (chronic obstructive pulmonary disease)?**

1 ○ Yes 0 ○ No 8 ○ Don't know LFCPCOPD

a. Was it diagnosed by a doctor or other health professional? 1 ○ Yes 0 ○ No LFCPDIAG

b. At about what age did it start? ☐☐ years old ○ Don't Know LFCPAGE 1 LFCPAGED

c. Do you still have it? 1 ○ Yes 0 ○ No 8 ○ Don't Know LFCPHAVE

d. In the past 12 months, have you received medical treatment, taken medications or used an inhaler for COPD? 1 ○ Yes 0 ○ No LFCPMED

12 **Have you ever had any other chest illnesses?**

1 ○ Yes 0 ○ No LFCHILL

Please specify:_____

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Respiratory Symptoms

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These questions are about respiratory or chest symptoms. Please answer Yes or No. If you are in doubt whether your answer is Yes or No, answer No.

13 **Have you ever had any chest operations?**

1 ○ Yes *0* ○ No *LFCHOPER*

Please specify: _____

14 **Have you ever had any chest injuries?**

1 ○ Yes *0* ○ No *LFCHINJR*

Please specify: _____

15 **Have you ever smoked cigarettes? (No means less than 20 packs of cigarettes or 12 oz. of tobacco in your lifetime or less than 1 cigarette a day for one year at any time in your life.)**

1 ○ Yes *0* ○ No *LFSMOKE* *TURSMOK2, TUPACKY2, TUPACKY3, TUSMYRS2*

a. How old were you when you first started regular cigarette smoking? *LFSMAGE* ☐☐ years old ○ Don't Know *1 LFSMAGED*

b. Do you now smoke cigarettes (as of one month ago)?

1 ○ Yes *0* ○ No *LFSMNOW*

1. How many cigarettes do you smoke per day now? *LFSMCIGD* ☐☐ cigarettes per day

2. Did you ever quit smoking for 6 months or longer? *LFSM6QT1*

1 ○ Yes *0* ○ No

For how many years in total did you quit smoking? ☐☐ *LFSMYRS1* years

3. On the average of the entire time you smoked, how many cigarettes did you smoke per day? ☐☐ cigarettes per day *LFSMCIG1*

1. How old were you when you completely stopped smoking? *LFSMSTOP* ☐☐ years old

2. When you were a smoker, did you ever quit smoking for 6 months or longer before you completely stopped smoking?

1 ○ Yes *0* ○ No *LFSM6QT2*

During the time that you were a smoker, for how many years in total did you quit smoking? ☐☐ *LFSMYRS2* years

3. On the average of the entire time you smoked, how many cigarettes did you smoke per day? ☐☐ cigarettes per day *LFSMCIG2*

QL1S2COM QLSS2COM QL3S2COM
QLIS2COM QL2S2COM

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Lifestyle

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MrOS ID# Acrostic

1 **Compared to other people your own age, how would you rate your overall health?** QLHEALTH QLCOMP

1○ Excellent for my age 2○ Good for my age 3○ Fair for my age 4○ Poor for my age 5○ Very poor for my age

---

The following questions are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?

	Yes, limited a lot	Yes, limited a little	No, not limited at all
2 Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling or playing golf? QLMODLIM	1○	2○	3○
3 Climbing several flights of stairs? QLSEVLIM	1○	2○	3○

---

4 **During the <u>past 4 weeks,</u> have you had any of the following problems with your work or other regular daily activities because of your <u>physical health</u>?**

a. **Accomplished less** than you would like QLACCOM 1○ Yes 0○ No

b. Were limited in the **kind** of work or other activities QLKIND 1○ Yes 0○ No

---

5 **During the <u>past 4 weeks</u>, have you had any of the following problems with your work or other regular daily activities because of any <u>emotional problems</u> (such as feeling depressed or anxious)?**

a. **Accomplished less** than you would like QLACCLV 1○ Yes 0○ No

b. Didn't do work or other activities as **carefully** as usual QLCARE 1○ Yes 0○ No

---

6 **During the <u>past 4 weeks</u>, how much did pain interfere with your normal work (including both work outside the home and housework)?** QLPAIN

0○ Not at all 1○ A little bit 2○ Moderately 3○ Quite a bit 4○ Extremely

---

7 **During the <u>past 4 weeks</u>, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting friends, relatives, etc.)?** QLSOCIAL

4○ All of the time 3○ Most of the time 2○ Some of the time 1○ A little of the time 0○ None of the time

Draft

Lifestyle

Office Use Only--
MrOS ID# | | | | | | | |

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Acrostic | | | | |

8 **These questions are about how you feel and how things have been with you during the past 4 weeks. For each question, please give the one answer that comes closest to the way you have been feeling. How much of the time during the <u>past 4 weeks</u> . . .**

a. Have you felt calm and peaceful? *QLCALM*

5○ All of the time *4*○ Most of the time *3*○ A good bit of the time *2*○ Some of the time *1*○ A little of the time *0*○ None of the time

b. Did you have a lot of energy? *QLENERGY*

5○ All of the time *4*○ Most of the time *3*○ A good bit of the time *2*○ Some of the time *1*○ A little of the time *0*○ None of the time

c. Have you felt downhearted and blue? *QLBLUE*

5○ All of the time *4*○ Most of the time *3*○ A good bit of the time *2*○ Some of the time *1*○ A little of the time *0*○ None of the time

These questions ask you how you are feeling <u>today</u>. Please indicate which statement best describes your own health state today.

9 **Mobility:** *QLEQMOB*
- *0*○ I have no problems walking about
- *1*○ I have some problems walking about
- *2*○ I am confined to bed

10 **Self-care:** *QLEQCARE*
- *0*○ I have no problems with self-care
- *1*○ I have some problems washing or dressing myself
- *2*○ I am unable to wash or dress myself

11 **Usual activities (e.g. work, study, housework, family or leisure activites)** *QLEQUSE*
- *0*○ I have no problems with performing my usual activites
- *1*○ I have some problems with performing my usual activities
- *2*○ I am unable to perform my usual activites

12 **Pain/discomfort:** *QLEQPAIN*
- *0*○ I have no pain or discomfort
- *1*○ I have moderate pain or discomfort
- *2*○ I have extreme pain or discomfort

13 **Anxiety/depression:** *QLEQANX*
- *0*○ I am not anxious or depressed
- *1*○ I am moderately anxious or depressed
- *2*○ I am extremely anxious or depressed

Draft

Draft

Physical Activity

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The next few questions ask about your physical activity during the last 7 days. If the last 7 days have not been typical because of illness or bad weather, please estimate based on two or three weeks ago.

1 **Over the past 7 days, how often did you participate in sitting activities such as reading, watching TV or doing handcrafts?**

0○ Never *1*○ Seldom (1-2 days) *2*○ Sometimes (3-4 days) *3*○ Often (5-7 days) *PASIT*

Go to Question 2

What were these activities? _____

_____

On average, how many hours per day did you engage in these sitting activities?

1○ Less than 1 hour *2*○ Between 1 and 2 hours *3*○ 2-4 hours *4*○ More than 4 hours *PASITT*

2 **Over the past 7 days, how often did you take a walk outside your home or yard for any reason? For example, for fun or exercise, walking to work, walking the dog, etc.?**

0○ Never *1*○ Seldom (1-2 days) *2*○ Sometimes (3-4 days) *3*○ Often (5-7 days) *PAWALK* *PAWALKW*

Go to Question 3

What were these activities? _____

_____

On average, how many hours per day did you spend walking? *PAWALKT*

1○ Less than 1 hour *2*○ Between 1 and 2 hours *3*○ 2-4 hours *4*○ More than 4 hours

3 **Over the past 7 days, how often did you engage in light sport or recreational activities such as bowling, golf with a cart, shuffleboard, fishing from a boat or pier, or other similar activities?** *PALTEW*

0○ Never *1*○ Seldom (1-2 days) *2*○ Sometimes (3-4 days) *3*○ Often (5-7 days) *PALTE*

Go to Question 4

What were these activities? _____

_____

On average, how many hours per day did you engage in these light sport or recreational activities? *PALTET*

1○ Less than 1 hour *2*○ Between 1 and 2 hours *3*○ 2-4 hours *4*○ More than 4 hours

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MrOSURPase1

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Physical Activity

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4 **Over the <u>past 7 days</u>, how often did you engage in moderate sport and recreational activities such as doubles tennis, ballroom dancing, hunting, ice skating, golf without a cart, softball or other similar activities?** *PAMOD*

0 ○ Never *1* ○ Seldom (1-2 days) *2* ○ Sometimes (3-4 days) *3* ○ Often (5-7 days) *PAMODW*

Go to Question 5

What were these activities? _____

_____

On average, how many hours per day did you engage in these moderate sport or recreational activities? *PAMODT*

1 ○ Less than 1 hour *2* ○ Between 1 and 2 hours *3* ○ 2-4 hours *4* ○ More than 4 hours

5 **Over the <u>past 7 days</u>, how often did you engage in strenuous sport and recreational activities such as jogging, swimming, cycling, singles tennis, aerobic exercise, skiing (downhill or cross country) or other similar activities?**

0 ○ Never *1* ○ Seldom (1-2 days) *2* ○ Sometimes (3-4 days) *3* ○ Often (5-7 days) *PASTR* *PASTRW*

Go to Question 6

What were these activities? _____

_____

On average, how many hours per day did you engage in these strenuous sport or recreational activities? *UTPASTRT*

1 ○ Less than 1 hour *2* ○ Between 1 and 2 hours *3* ○ 2-4 hours *4* ○ More than 4 hours

6 **Over the <u>past 7 days</u>, how often did you do any exercise specifically to increase muscle strength and endurance, such as lifting weights or pushups, etc.?**

0 ○ Never *1* ○ Seldom (1-2 days) *2* ○ Sometimes (3-4 days) *3* ○ Often (5-7 days) *PAWGT* *PAWGTW*

Go to Question 7

What were these activities? _____

_____

On average, how many hours per day did you engage in exercises to increase muscle strength and endurance? *PAWGTT*

1 ○ Less than 1 hour *2* ○ Between 1 and 2 hours *3* ○ 2-4 hours *4* ○ More than 4 hours

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MrOSUTPase2

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Physical Activity

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7 **During the <u>past 7 days</u>, have you done any light housework, such as dusting or washing dishes?**

1○ Yes *0*○ No *PALHW* *PALHWW*

8 **During the <u>past 7 days</u>, have you done any heavy housework or chores, such as vacuuming, scrubbing floors, washing windows or carrying wood?**

1○ Yes *0*○ No *PAHHW* *PAHHWW*

9 **During the <u>past 7 days</u>, did you engage in any of the following activities? (Please answer yes or no for each item.)**

PAHOMEW

Home repairs, like painting, wallpapering, electrical work, etc.? *1*○ Yes *0*○ No *PAHOME*

PALAWNW

Lawn work or yard care, including snow or leaf removal, wood chopping, etc.? *1*○ Yes *0*○ No *PALAWN*

PAGARDENW

Outdoor gardening? *1*○ Yes *0*○ No *PAGARDEN*

PACAREW

Caring for another person, such as children, dependent spouse, or another adult? *1*○ Yes *0*○ No *PACARE*

10 **During the <u>past 7 days</u> did you work either for pay or as a volunteer?**

1○ Yes *0*○ No

↓ *PAWK* *PAWKW*

a. How many hours in the past week did you work for pay and/or as a volunteer? | | | *PAWKHR* **hours**

b. Which of the following categories best describes the amount of physical activity required on your job and/or volunteer work?

1○ Mainly sitting with slight arm movements

Examples: office worker, watchmaker, seated assembly line worker, bus driver, etc.

2○ Sitting or standing with some walking *PAWKPA*

Examples: cashier, general office worker, light tool and machinery worker

3○ Walking, with some handling of materials generally weighing less than 50 pounds

Examples: mailman, waiter/waitress, construction worker, heavy tool and machinery worker

4○ Walking and heavy manual work often requiring handling material weighing more than 50 pounds

Examples: lumberjack, stone mason, farm or general laborer.

PASCORE

PASELEIS
PASEHOUS
PASEOCC

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MrOSUUPase3

MrOS Sleep Visit 2

Mr. OS Sleep

Draft

Draft

Caffeine, Tobacco & Alcohol

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1 **Do you currently drink regular coffee? (Not decaffeinated)** 1○ Yes 0○ No

↓ CFCCOF

How many cups of REGULAR coffee do you drink per day? CFCCUP ____ **cups**

2 **Do you currently drink regular tea? (Not herbal or decaffeinated)** 1○ Yes 0○ No

↓ CFCTEA

How many cups of REGULAR tea do you drink per day? CFTCUP ____ **cups**

3 **Do you currently drink sodas that contain caffeine, such as Pepsi, Coca-Cola, Dr. Pepper, and Mountain Dew? (Do NOT include Sprite or 7-up or other sodas without caffeine)** 1○ Yes 0○ No

↓ CFCCOK

How many cans of CAFFEINATED soda do you drink per day? CFCCAN ____ **cans**

4 **Do you currently smoke a pipe or cigars regularly?** 1○ Yes 0○ No

↓ TUPIPEC

About how much do you smoke per week? ____ TUCPIAMT **pipes or cigars per week**

5 **In the past 12 months, have you had at least 12 drinks of any kind of alcoholic beverage?** 1○ Yes 0○ No 8○ I don't know

↓ TU12DRIN

On average, how many alcoholic drinks do you consume per week? TUDRAMT

1○ Less than one drink per week
2○ 1-2 drinks per week
3○ 3-5 drinks per week
4○ 6-13 drinks per week
5○ 14 or more drinks per week

CFCAFF

TURSMOK1

Draft

Moods in the Last Week

Office Use Only-- MrOS ID#							○ MISSING Acrostic			

Choose the best answer for how you felt over the LAST WEEK.

1	Are you basically satisfied with your life? DPSAT	1 ○ Yes	0 ○ No
2	Have you dropped many of your activities and interests? DPDROP	1 ○ Yes	0 ○ No
3	Do you feel that your life is empty? DPEMPT	1 ○ Yes	0 ○ No
4	Do you often get bored? DPBORE	1 ○ Yes	0 ○ No
5	Are you in good spirits most of the time? DPGOOD	1 ○ Yes	0 ○ No
6	Are you afraid something bad is going to happen to you? DPSBAD	1 ○ Yes	0 ○ No
7	Do you feel happy most of the time? DPHAPY	1 ○ Yes	0 ○ No
8	Do you often feel helpless? DPHPLS	1 ○ Yes	0 ○ No
9	Do you prefer to stay at home, rather than going out and doing new things? DPHOME	1 ○ Yes	0 ○ No
10	Do you feel you have more problems with memory than most? DPMEM	1 ○ Yes	0 ○ No
11	Do you think it is wonderful to be alive now? DPWOND	1 ○ Yes	0 ○ No
12	Do you feel pretty worthless the way you are now? DPWRTH	1 ○ Yes	0 ○ No
13	Do you feel full of energy? DPENER	1 ○ Yes	0 ○ No
14	Do you feel that your situation is hopeless? DPSIT	1 ○ Yes	0 ○ No
15	Do you think that most people are better off than you are? DPMOST	1 ○ Yes	0 ○ No

DPGDSSC
DPGDS15
DPGDSYN

Feelings

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Office Use Only-- MrOS ID#							○ MISSING Acrostic			

Choose the best answer for how you have been feeling over the LAST MONTH.

1	**Have you felt keyed up or on edge?**	*AXKEYED*	1 ○ Yes	0 ○ No
2	**Have you been worrying a lot?**	*AXWORRY*	1 ○ Yes	0 ○ No
3	**Have you been irritable?**	*AXIRTBL*	1 ○ Yes	0 ○ No
4	**Have you had difficulty relaxing?**	*AXRELAX*	1 ○ Yes	0 ○ No
5	**Have you been sleeping poorly?**	*AXPOORSP*	1 ○ Yes	0 ○ No
6	**Have you had headaches or neckaches?**	*AXNKACHE*	1 ○ Yes	0 ○ No
7	**Have you had any of the following: trembling, tingling, dizzy spells, sweating, diarrhea or needing to pass water more often than usual?**	*AXTREMB*	1 ○ Yes	0 ○ No
8	**Have you been worried about your health?**	*AXWORHTL*	1 ○ Yes	0 ○ No
9	**Have you had difficulty falling asleep?**	*AXDIFSLP*	1 ○ Yes	0 ○ No
10	**Have you been lacking energy?**	*AXENRGY*	1 ○ Yes	0 ○ No
11	**Have you lost interest in things?**	*AXLOST*	1 ○ Yes	0 ○ No
12	**Have you lost confidence in yourself?**	*AXCONFID*	1 ○ Yes	0 ○ No
13	**Have you felt hopeless?**	*AXHOPELS*	1 ○ Yes	0 ○ No
14	**Have you had difficulty concentrating?**	*AXCONCNT*	1 ○ Yes	0 ○ No
15	**Have you lost weight (due to poor appetite)?**	*AXLOSTWT*	1 ○ Yes	0 ○ No
16	**Have you been waking early?**	*AXEARLY*	1 ○ Yes	0 ○ No
17	**Have you felt slowed up?**	*AXSLOWED*	1 ○ Yes	0 ○ No
18	**Have you tended to feel worse in the morning?**	*AXWORSE*	1 ○ Yes	0 ○ No

AXANXSC
AXANX50
AXDEPSC
AXDEP50

Draft

Enrollment Form

Office Use Only-- MrOS ID#	Acrostic	Staff ID#

1 **Is participant willing to complete the MrOS Sleep Visit?**

VS21FUTM VS22FUTM VS2DFUTM VS23FUTM VS2IFUTM VS2I2FUTM VS2SFUTM

VS21FYTM VS22FYTM VS2DFYTM VS23FYTM VS2IFYTM VS2I2FYTM VS2SFYTM

○ Yes ○ No →

Reason:
- ○ Not interested/Too busy
- ○ Health Problems
- ○ Out of Area
- ○ Too many contacts from study
- ○ Caregiver responsibilities
- ○ Postcard Only status (not contacted)
- ○ Other _____

SCREENING QUESTIONS:

A. Do you have an open tracheostomy? ○ Yes ○ No

NOT ELIGIBLE - SKIP TO QUESTION D

B. In the past three months, have you used any of the following items? (Mark all that apply)

-1 ○ Pressure mask ("CPAP" or "BiPAP" for sleep apnea) *VS2CPAP* →
When do you usually wear it?
- ○ During sleep and wake
- ○ During sleep only
- ○ During wake only

VS2CPAP1

-1 ○ Mouthpiece (for snoring) *VS2MPIECE* →
When do you usually wear it?
- ○ During sleep and wake
- ○ During sleep only
- ○ During wake only

VS2MPIEC1

-1 ○ Oxygen therapy *VS2OXTHER* →
When do you usually wear it?
- ○ During sleep and wake
- ○ During sleep only
- ○ During wake only

VS2OXTHE1

-1 ○ None *VS2ESNONE*

NOTE: **Please ensure that the participant has not had any active respiratory symptoms (exacerbation, new cough, or wheezing), obvious respiratory distress or recent onset of chest pains in the past two weeks. If so, please reschedule visit in two weeks.**

C. Is participant eligible for actigraphy? ○ Yes ○ No

D. Did participant complete the MrOS Sleep visit? ○ Yes ○ Not eligible

a. Date of visit: ☐☐ / ☐☐ / ☐☐☐☐ *VS2SLDATE*
Month Day Year

b. Who completed the SAQ? *VS2SLSAQ* *1* ○ Participant *2* ○ Spouse *3* ○ Other family *4* ○ Clinic *5* ○ Other

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Sleep History

Office Use Only-- MrOS ID#	○ MISSING Acrostic

1 **How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently try to think about out how they would have affected you. Give the most appropriate response for each situation.**

EPEPWORT *EPEDS*

	Would **Never** Doze	**Slight** Chance of Dozing	**Moderate** Chance of Dozing	**High** Chance of Dozing
a. Sitting and reading *EPREAD*	○*0*	○*1*	○*2*	○*3*
b. Watching TV *EPTV*	○*0*	○*1*	○*2*	○*3*
c. Sitting inactive in a public place (e.g. a theater or a meeting) *EPPUB*	○*0*	○*1*	○*2*	○*3*
d. As a passenger in a car for an hour without a break *EPCAR*	○*0*	○*1*	○*2*	○*3*
e. Lying down to rest in the afternoon when circumstances permit *EPREST*	○*0*	○*1*	○*2*	○*3*
f. Sitting and talking to someone *EPTALK*	○*0*	○*1*	○*2*	○*3*
g. Sitting quietly after a lunch without alcohol *EPEAT*	○*0*	○*1*	○*2*	○*3*
h. In a car, while stopped for a few minutes in traffic *EPTRAF*	○*0*	○*1*	○*2*	○*3*

2 **Do you ever experience a desire to move your legs or arms because of discomfort or disagreeable sensations in your legs or arms?** *SLRLDES*

1○ Yes *0*○ No *8*○ Don't know

↓

a. 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?
1○ Yes *0*○ No *8*○ Don't know *SLRLRELV*

b. Are these symptoms worse when you are at rest (i.e., sitting quietly), with at least temporary relief by activity?
1○ Yes *0*○ No *8*○ Don't know *SLRLREST*

c. Are these symptoms worse later in the day or at night, than in the morning?
1○ Yes *0*○ No *8*○ Don't know *SLRLLATR*

(If participant answers 'Yes' to 2a, have him answer the questions from the Restless Legs Syndrome Rating Scale on the following page)

Draft

Restless Legs Syndrome Rating Scale

Office Use Only-
MrOS ID# | Acrostic | Staff ID# CCSTAFF

Instructions: If participant answers 'Yes' to 2a on the previous page, have him rate his symptoms for the following questions. The examiner should mark his answers on the form and clarify any misunderstandings he may have about the questions.

Was the Restless Legs Syndrome Rating Scale administered? 1 ○ Yes 0 ○ No SLRLSADM

SLRLWHYN **Why not?** 1 ○ Not required 7 ○ Refused 2 ○ Other

1. **In the PAST MONTH, overall, how would you rate the RLS discomfort in your legs or arms?**
   4 ○ Very Severe 3 ○ Severe 2 ○ Moderate 1 ○ Mild 0 ○ None SLRLDISC

2. **In the PAST MONTH, overall, how would you rate the <u>need to move</u> around because of your RLS symptoms?**
   4 ○ Very Severe 3 ○ Severe 2 ○ Moderate 1 ○ Mild 0 ○ None SLRLMOV

3. **In the PAST MONTH, overall, how much <u>relief</u> of your RLS arm or leg discomfort did you get from moving around?** SLRLREL
   4 ○ No relief 3 ○ Mild relief 2 ○ Moderate relief 1 ○ Complete or almost complete relief 0 ○ Does not apply

4. **In the PAST MONTH, how severe is your <u>sleep disturbance</u> due to your RLS symptoms?**
   4 ○ Very Severe 3 ○ Severe 2 ○ Moderate 1 ○ Mild 0 ○ None SLRLSLPD

5. **In the PAST MONTH, how severe is your <u>tiredness</u> or <u>sleepiness during the day</u> due to your RLS symptoms?**
   4 ○ Very Severe 3 ○ Severe 2 ○ Moderate 1 ○ Mild 0 ○ None SLRLTIRE

6. **In the PAST MONTH, how severe was <u>your RLS as a whole</u>?**
   4 ○ Very Severe 3 ○ Severe 2 ○ Moderate 1 ○ Mild 0 ○ None SLRLSYMP

7. **In the PAST MONTH, how <u>often</u> did you get RLS symptoms?** SLRLOFTN
   4 ○ 6-7 days a week 3 ○ 4-5 days a week 2 ○ 2-3 days a week 1 ○ 1 day a week or less 0 ○ Never

8. **In the PAST MONTH, when you had RLS symptoms, how <u>severe</u> were they on <u>average</u>?**
   4 ○ 8 hours per day or more 3 ○ 3-8 hours per day 2 ○ 1-3 hours per day 1 ○ 1 hour per day 0 ○ None SLRLSEVR

9. **In the PAST MONTH, overall, how severe is the impact of your RLS symptoms on your ability to carry out your <u>daily affairs</u>, for example carrying out a satisfactory family, home, social, or work life?**
   4 ○ Very Severe 3 ○ Severe 2 ○ Moderate 1 ○ Mild 0 ○ None SLRLAFFR

10. **In the PAST MONTH, how severe was your mood disturbance due to your RLS symptoms- for example angry, depressed, sad, anxious, or irritable?**
    4 ○ Very Severe 3 ○ Severe 2 ○ Moderate 1 ○ Mild 0 ○ None SLRLMOOD

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Insomnia Severity Index

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For each question below, please choose the answer corresponding most accurately to your sleep patterns in the LAST MONTH.

For the first three questions, please rate the SEVERITY of your sleep difficulties.

1. **Difficulty falling asleep:** *SLFALSLP*
   5○ None *4*○ Mild *3*○ Moderate *2*○ Severe *1*○ Very Severe

2. **Difficulty staying asleep:** *SLSTYSLP*
   5○ None *4*○ Mild *3*○ Moderate *2*○ Severe *1*○ Very Severe

3. **Problem waking up too early in the morning:** *SLWKERLY*
   5○ None *4*○ Mild *3*○ Moderate *2*○ Severe *1*○ Very Severe

4. **How SATISFIED/DISSATISFIED are you with your current sleep pattern?**
   0○ Very Satisfied *1*○ Satisfied *2*○ Neutral *3*○ Dissatisfied *4*○ Very Dissatisfied
   SLSATPAT

These next questions ask about any potential sleep problems you may have had in the LAST MONTH.

5. **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	A little interfering	Somewhat interfering	Much interfering	Very much interfering
SLPRINTR	*0*○	*1*○	*2*○	*3*○	*4*○

6. **How NOTICEABLE to others do you think your sleeping problem is in terms of impairing the quality of your life?**

	Not at all noticeable	A little noticeable	Somewhat noticeable	Much noticeable	Very much noticeable
SLPRNOTC	*0*○	*1*○	*2*○	*3*○	*4*○

7. **How WORRIED/DISTRESSED are you about your sleep problem?**
   0○ Not at all *1*○ A little *2*○ Somewhat *3*○ Much *4*○ Very Much *SLPRWORR*

SLISISCR
SLISICAT

Version 1.0 07.08.2009
MrOSCDInsomniaSeverityIndex
MrOS Sleep Visit 2

Mr. OS Sleep

Draft

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Fatigue Scale

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MrOS ID# Acrostic

1 **This next question refers to the past month. In the past month, on the average, have you been feeling unusually tired during the day?**

SLTIRE 1○ Yes 0○ No 8○ Don't know 7○ Refused

Have you been feeling unusually tired...? *SLOFTN*

1○ All of the time 2○ Most of the time 3○ Some of the time 8○ Don't know

2 **During the past month, how weak did you feel? Using this card, please choose the best category, where 0 is "not weak at all" and 10 is "very weak."**

○0 ○1 ○2 ○3 ○4 ○5 ○6 ○7 ○8 ○9 ○10 11○ Don't Know 12○ Refused

SLWKLEV

3 **During the past month, how sleepy did you feel during the day? Using this card, please choose the best category, where 0 is "not sleepy at all" and 10 is "very sleepy."**

○0 ○1 ○2 ○3 ○4 ○5 ○6 ○7 ○8 ○9 ○10 11○ Don't Know 12○ Refused

SLSLPLEV

4 **During the past month, how lively did you feel? Using this card, please choose the best category, where 0 is "not lively at all" and 10 is "very lively."**

○0 ○1 ○2 ○3 ○4 ○5 ○6 ○7 ○8 ○9 ○10 11○ Don't Know 12○ Refused

SLLIVLEV

5 **During the past month, how tired did you feel? Using this card, please choose the best category, where 0 is "not tired at all" and 10 is "very tired."**

○0 ○1 ○2 ○3 ○4 ○5 ○6 ○7 ○8 ○9 ○10 11○ Don't Know 12○ Refused

SLTIRLEV

6 **Using this card, please choose the category that best describes your usual energy level in the past month on a scale of 0 to 10 where 0 is "no energy" and 10 is "the most energy" that you have ever had.**

○0 ○1 ○2 ○3 ○4 ○5 ○6 ○7 ○8 ○9 ○10 11○ Don't Know 12○ Refused

SLENRLEV

Draft

Functional Status

Office Use Only-- MrOS ID#							○ MISSING Acrostic			

The following questions are about how well you are able to do certain activities, by yourself and without using any special aids.

QLBLK1 QLBLK2 QLRBLK1

1 Do you have ANY difficulty walking 2 or 3 blocks outside on level ground?

1 ○ Yes 0 ○ No 2 ○ I don't do it QLBLK

GO TO QUESTION #2

How much difficulty do you have doing this? QLBLKLVL
1 ○ Some difficulty 2 ○ Much difficulty 3 ○ Unable to do it

Is this because of a health or physical problem? QLBLKPRB
1 ○ Yes 0 ○ No 8 ○ I don't know

QLSTP1 QLSTP2 QLRSTP1

2 Do you have ANY difficulty climbing up 10 steps without resting?

1 ○ Yes 0 ○ No 2 ○ I don't do it QLSTP

GO TO QUESTION #3

How much difficulty do you have doing this? QLSTPLVL
1 ○ Some difficulty 2 ○ Much difficulty 3 ○ Unable to do it

Is this because of a health or physical problem? QLSTPPRB
1 ○ Yes 0 ○ No 8 ○ I don't know

QLMEL1 QLMEL2 QLRMEL1

3 Do you have ANY difficulty preparing your own meals?

1 ○ Yes 0 ○ No 2 ○ I don't do it QLMEL

GO TO QUESTION #4

How much difficulty do you have doing this? QLMELLVL
1 ○ Some difficulty 2 ○ Much difficulty 3 ○ Unable to do it

Is this because of a health or physical problem? QLMELPRB
1 ○ Yes 0 ○ No 8 ○ I don't know

QLHHW1 QLHHW2 QLRHHW

4 Do you have ANY difficulty doing heavy housework, like scrubbing floors or washing windows?

1 ○ Yes 0 ○ No 2 ○ I don't do it QLHHW

GO TO QUESTION #5

How much difficulty do you have doing this? QLHHWLVL
1 ○ Some difficulty 2 ○ Much difficulty 3 ○ Unable to do it

Is this because of a health or physical problem? QLHHWPRB
1 ○ Yes 0 ○ No 8 ○ I don't know

QLSHP1 QLSHP2 QLRSHP1

5 Do you have ANY difficulty doing your own shopping for groceries or clothes?

1 ○ Yes 0 ○ No 2 ○ I don't do it QLSHP

GO TO QUESTION #6

How much difficulty do you have doing this? QLSHPLVL
1 ○ Some difficulty 2 ○ Much difficulty 3 ○ Unable to do it

Is this because of a health or physical problem? QLSHPPRB
1 ○ Yes 0 ○ No 8 ○ I don't know

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The following questions are about how well you are able to do certain activities, by yourself and without using any special aids.

QLMON1 QLMON2 QLRMON1

6 Do you have ANY difficulty managing money?

1 ○ Yes 0 ○ No 2 ○ I don't do it *QLMON*

GO TO QUESTION #7

How much difficulty do you have doing this?
1 ○ Some difficulty 2 ○ Much difficulty 3 ○ Unable to do it
QLMONLVL

Is this because of a health or physical problem?
1 ○ Yes 0 ○ No 8 ○ I don't know
QLMONPRB

QLBAT1 QLBAT2 QLRBAT1

7 Do you have ANY difficulty bathing or showering?

1 ○ Yes 0 ○ No 2 ○ I don't do it *QLBAT*

GO TO QUESTION #8

How much difficulty do you have doing this?
1 ○ Some difficulty 2 ○ Much difficulty 3 ○ Unable to do it
QLBATLVL

Is this because of a health or physical problem?
1 ○ Yes 0 ○ No 8 ○ I don't know
QLBATPRB

QLBED1 QLBED2 QLRBED1

8 Do you have ANY difficulty getting in and out of beds or chairs?

1 ○ Yes 0 ○ No 2 ○ I don't do it *QLBED*

GO TO QUESTION #9

How much difficulty do you have doing this?
1 ○ Some difficulty 2 ○ Much difficulty 3 ○ Unable to do it
QLBEDLVL

Is this because of a health or physical problem?
1 ○ Yes 0 ○ No 8 ○ I don't know
QLBEDPRB

QLMED1 QLMED2 QLRMED1

9 Do you have ANY difficulty managing your medications?

1 ○ Yes 0 ○ No 2 ○ I don't do it *QLMED*

GO TO NEXT SECTION

How much difficulty do you have doing this?
1 ○ Some difficulty 2 ○ Much difficulty 3 ○ Unable to do it
QLMEDLVL

Is this because of a health or physical problem?
1 ○ Yes 0 ○ No 8 ○ I don't know
QLMEDRB

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Teng Mini-Mental

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Introduction: 'Are you comfortable? I would like to ask you a few questions that require concentration and memory. Some are a little bit more difficult than others. Some questions will be asked more than once."

A. Was the Mini-Mental test administered? 1 ○ Yes 0 ○ No → TMTEST

Why not? 1 ○ Refused 2 ○ Other: TMWHYN

B. What time was the Mini-Mental test administered (start time)? TMTIMEM ☐☐ : ☐☐ ○ A.M. ○ P.M.

1

A. When were you born?

☐☐ / ☐☐ / ☐☐☐☐
Month / Day / Year

B. Where were you born? Place of Birth?

	Answer given*	Can't do/ Refused	Not attempted
_____ City or town	○	○	○
_____ State/Country	○	○	○

*** If answer is given, you wil ask again in question #18**

2

I am going to say three words for you to remember. Repeat them after I have said all three words:

Shirt, Blue, Honesty

Do not repeat the words for the participant until after the first trial. The participant may give the words in any order. If there are errors on the first trial, repeat the items up to six times until they are learned.

	Correct	Error/ Refused	Not attempted
A. Shirt	○	○	○
B. Blue	○	○	○
C. Honesty	○	○	○

D. Number of presentations necessary for the participant to repeat the sequence ☐ CJTMNUM **presentations**

3

A. I would like you to count from 1 to 5.

○ Able to count forward ○ Unable to count forward → **Say "1,2,3,4,5"**

B. Now I would like you to count backwards from 5 to 1.

☐☐☐☐☐

Record the response in the order given. Enter 99999 if no response.

4

A. Spell 'world'.

○ Able to spell ○ Unable to spell → **Say "Its spelled W-O-R-L-D"**

B. Now spell world backwards

☐☐☐☐☐

Record the response in the order given. Enter XXXXX if no response.

SEE PAGE 11 FOR SCORING VARIABLES

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5 **What three words did I ask you to remember?**

A. Shirt
- ○ Spontaneous recall
- ○ Correct word, incorrect form
- ○ After 'Something to wear'
- ○ After 'Shirt, shoes, socks'
- ○ Unable to recall/refused
- ○ Not attempted

B. Blue
- ○ Spontaneous recall
- ○ Correct word, incorrect form
- ○ After 'A color'
- ○ After 'Blue, black, brown'
- ○ Unable to recall/refused
- ○ Not attempted

C. Honesty
- ○ Spontaneous recall
- ○ Correct word, incorrect form
- ○ After 'A good personal quality'
- ○ After 'Honesty, charity, modesty'
- ○ Unable to recall/refused
- ○ Not attempted

6 **A. What is today's date?**

Month / Day / Year

B. What is the day of the week?
- ○ Correct
- ○ Error/Refused _____ **day of the week**
- ○ Not attempted

C. What season of the year is it?
- ○ Correct
- ○ Error/Refused _____ **season**
- ○ Not attempted

7 **A. What state are we in?**
- ○ Correct
- ○ Error/Refused _____ **state**
- ○ Not attempted

B. What county are we in?
- ○ Correct
- ○ Error/Refused _____ **county**
- ○ Not attempted

C. What city/town are we in?
- ○ Correct
- ○ Error/Refused _____ **city/town**
- ○ Not attempted

D. Are we in a clinic, store, or home?
- ○ Correct
- ○ Error/Refused _____
- ○ Not attempted

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8 Point to the object or part of your own body and ask the participant to name it. Score 'Error/Refused' if the participant cannot name it within 2 seconds or gives an incorrect name.

	Correct	Error/ Refused	Not attempted
A. Pencil: 'What is this?'	○	○	○
B. Watch: 'What is this?'	○	○	○
C. Forehead: 'What do you call this part of the face?'	○	○	○
D. Chin: 'And this part?'	○	○	○
E. Shoulder: 'And this part of the body?'	○	○	○
F. Elbow: 'And this part?'	○	○	○
G. Knuckle: 'And this part?'	○	○	○

9 **What animals have four legs? Tell me as many as you can.**

Discontinue after 30 seconds. If the participant gives no reponse in 10 secs and there are at least 10 secs remaining, gently remind them (once only): 'What (other) animals have four legs?'. The first time an incorrect answer is provide, say 'I want four-legged animals.' Do not correct for subsequent errors.

Score (total correct responses) ☐☐

Record correct responses:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Record additional correct answers on a separate sheet

10

A. In what way are an arm and a leg alike?

○ Limbs, extremities, appendages
○ Lesser correct answer (e.g., body parts, both bend, have joints)
○ Error/Refused
○ Not attempted

B. In what way are laughing and crying alike?

○ Expressions of feelings, expressions of emotions
○ Lesser correct answer (e.g., sounds, expressions, emotions, or other similar responses)
○ Error/Refused
○ Not attempted

C. In what way are eating and sleeping alike?

○ Necessary bodily functions, essential for life
○ Lesser correct answer (e.g., bodily functions, relaxing, 'good for you' or other similar responses)
○ Error/Refused
○ Not attempted

11

Repeat what I say: 'I would like to go out.'

○ Correct
○ 1 or 2 words missed
○ 3 or more words missed
○ Not attempted

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12 **Now repeat: 'No ifs, ands or buts.'**

	Correct	Error/ Refused	Not attempted
A. no ifs	○	○	○
B. ands	○	○	○
C. or buts	○	○	○

13 **Hold up Card #1 and say: 'Please do this.'**

If participant does not close their eyes within 5 secs, prompt by pointing to the card and saying 'Read and do what this says.'

- ○ Closes eyes without prompting
- ○ Closes eyes after prompting
- ○ Reads aloud, but does not close eyes
- ○ Does not read aloud or close eyes/Refused
- ○ Not attempted

14 **Please write the following sentence: I would like to go out.**

	Correct	Error/ Refused	Not attempted
A. would	○	○	○
B. like	○	○	○
C. to	○	○	○
D. go	○	○	○
E. out	○	○	○

Which hand does the participant use to write? If task not done, ask if they are right or left handed.

1○ Right *2*○ Left *3*○ Unknown

TMHAND

15 **Here is a drawing. Please copy the drawing onto this piece of paper.**

A. Pentagon 1

- ○ 5 approximately equal sized sides
- ○ 5 sides, but longest:shortest side is >2:1
- ○ Nonpentagon enclosed figure
- ○ 2 or more lines, but it is not an enclosed figure
- ○ Less than 2 lines, Refused
- ○ Not attempted

B. Pentagon 2

- ○ 5 approximately equal sized sides
- ○ 5 sides, but longest:shortest side is >2:1
- ○ Nonpentagon enclosed figure
- ○ 2 or more lines, but it is not an enclosed figure
- ○ Less than 2 lines, Refused
- ○ Not attempted

C. Intersection

- ○ 4-cornered enclosure
- ○ Not a 4-cornered enclosure
- ○ No enclosure, Refused
- ○ Not attempted, Disabled

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16 Refer to Question 14 to check whether the participant is right or left-handed.

Take this paper with your left hand (right for left-handed person), fold it in half using both hands, and hand it back to me.

	Correct	Error/ Refused	Not attempted
A. Takes paper in correct hand	○	○	○
B. Folds paper in half	○	○	○
C. Hands paper back	○	○	○

17 **What three words did I ask you to remember earlier?**

A. Shirt
- ○ Spontaneous recall
- ○ Correct word, incorrect form
- ○ After 'Something to wear'
- ○ After 'Shirt, shoes, socks'
- ○ Unable to recall/refused
- ○ Not attempted

B. Blue
- ○ Spontaneous recall
- ○ Correct word, incorrect form
- ○ After 'A color'
- ○ After 'Blue, black, brown'
- ○ Unable to recall/refused
- ○ Not attempted

C. Honesty
- ○ Spontaneous recall
- ○ Correct word, incorrect form
- ○ After 'A good personal quality'
- ○ After 'Honesty, charity, modesty'
- ○ Unable to recall/refused
- ○ Not attempted

18 **Would you please tell me again where you were born?**

	Matches	Does not match/ Refused	Not attempted
_____ **City or town**	○	○	○
_____ **State/Country**	○	○	○

19 **Please indicate if the participant has any physical/functional disabilities or other problems which made it difficult or impossible to complete any of the tasks above. Check all that apply.**

- ○ Vision *1 TMDIFFVI*
- ○ Hearing *1 TMDIFFHE*
- ○ Writing problems due to injury or illness *1 TMDIFFWR*
- ○ Iliteracy/Lack of education *1 TMDIFFIL*
- ○ Language *1 TMDIFFLA*
- ○ Other: *1 TMDIFFOT*

TMMFLAG
TMBDAY
TMREGIS
TMREVERS
TMRECALL
TMTEMPUR
TMSPACE
TMNAMING
TM4LEG
TMMSCORE

TMM1SSCR

TMM1S2SC
TMMSS2SC
TMM2S2SC
TMM3S2SC

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Trail Making Task B & DVT

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1 **Was the participant able to complete the Sample Response Sheet?** 1○ Yes 0○ No TBSAMP

Why not? 1○ Unable due to physical problems (hand tremor, cast, etc.) 3○ Other
2○ Participant did not understand directions 4○ Participant Refused TBWHYN

2 **Was the Trails B test administered?** 1○ Yes 0○ No → 1○ Did not complete sample test 2○ Refused 3○ Other
TBTEST TBTEWHYN

What time was the Trails B test administered (start time)? ☐☐ : ☐☐ ○ A.M. ○ P.M. TBTIMEM

Number of circles connected (maximum=25): TBCIRCLE ☐☐ circles

Total time (max=300 seconds or 5 minutes): TBSECON ☐☐☐ secs

# of errors made by participant (max=5): TBERROR ☐ errors

Please note: If secs<300, circles=25. If errors=5, secs=300

Is the hand being used to complete Trails B the participant's usual or dominant hand for writing? 1○ Yes 0○ No TBDOMH

Are there any peripheral injuries (e.g., crushed or missing fingers, broken bones in the hand) or other things that have occurred in the participant's life history that would adversely affect their ability to do the test? 1○ Yes 0○ No TBAFFECT

Did the participant have a hand tremor (dominant hand)? 0○ No 1○ Mild 2○ Marked TBTREM

Digit Vigilance Test

DVT Staff ID# ☐☐☐☐ DVSTAFF

1 **Did participant complete the sample vigilance test?** 1○ Yes 0○ No DVVIGIL

Why not? DVVIGNO
1○ Unable 2○ Did not understand directions 3○ Other 4○ Refused

2 **Did participant complete page 1 in <400 seconds (6 minutes 40 seconds)?** 1○ Yes 0○ No DVVIGPG1

If NO, Do NOT have participant complete page 2. Record time and errors for page 1 ONLY below.

3 **Total Time:** ☐☐☐ DVTIME **seconds**

NOTE: If both pages completed record TOTAL time and errors.

4 **Omission Errors:** ☐☐☐ errors DVOMERR

Commission Errors: ☐☐☐ errors DVCOMERR

DVTOTERR

Minutes/Seconds to Second Conversions

Minutes	Seconds	Minutes	Seconds
1:00	60	**5:00**	**300**
1:15	75	5:15	315
1:30	90	5:30	330
1:45	105	5:45	345
2:00	120	6:00	360
2:15	135	6:15	375
2:30	150	6:30	390
2:45	165	**6:40**	**400**
3:00	180	6:45	405
3:15	195	7:00	420
3:30	210	7:15	435
3:45	225	7:30	450
4:00	240	7:45	465
4:15	255	8:00	480
4:30	270	8:15	495
4:45	285	8:30	510

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Height, Weight & Circumference

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1 **Was STANDING HEIGHT measured?** 1○ Yes 0○ No → **Explain:** _____

HWHEIGHT

a. Is the participant standing sideways due to kyphosis? HWKYPH 1○ Yes 0○ No

Measurement 1 HWMEAS1 ____ mm

Measurement 2 HWMEAS2 ____ mm

b. Do Measurement 1 and Measurement 2 differ by 4 or more mm? 1○ Yes 0○ No HWHGT

HWGT4

Complete Measurements 3 & 4

Measurement 3 HWMEAS3 ____ mm

Measurement 4 HWMEAS4 ____ mm

2 **Was WEIGHT measured?**

HWWEIGHT 1○ Yes 0○ No → **Explain:** _____

HWBM

HW1S2BMI HW2S2BMI HWDS2BMI HW3S2BMI HWSS2BMI

HWWGT ____.____ kg

HW1S2WT HWDS2WT HWSS2WT HW2S2WT HW3S2WT

HW1S2WPC HWDS2WPC HWSS2WPC HW2S2WPC HW3S2WPC

HWWTS225

3 **Were the circumference measurements taken?**

HWCIRCUM 1○ Yes 0○ No → **Explain:** _____

Round up to the nearest 0.1cm.

	1st Reading	2nd Reading	3rd Reading
HWNECK **a. Neck**	HWNECK1 ____.____ cm	HWNECK2 ____.____ cm	HWNECK3 ____.____ cm
HWWAIS **b. Waist**	HWWAIS1 ____.____ cm	HWWAIS2 ____.____ cm	HWWAIS3 ____.____ cm
HWHIP **c. Hip**	HWHIP1 ____.____ cm	HWHIP2 ____.____ cm	HWHIP3 ____.____ cm

HWSS2NCK HWSS2HIP HW3S2NCK HW3S2HIP HWSS2WST HW3S2WST

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Grip Strength

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EXCLUSION CRITERIA:

1 Has any pain or arthritis in your hands gotten worse recently?

1 ○ Yes 0 ○ No 7 ○ Refused 8 ○ Don't Know GSWEAK

Which side? 1 ○ Left 2 ○ Right 3 ○ Both GSSDWEAK

- 1 Left → DO NOT TEST LEFT
- 2 Right → DO NOT TEST RIGHT
- 3 Both → DO NOT TEST EITHER SIDE

2 Have you had any surgery on your hands or wrists in the past 3 months (12 weeks)?

1 ○ Yes 0 ○ No CQGSSURG

Which side? 1 ○ Left 2 ○ Right 3 ○ Both GSSDSURG

- 1 Left → DO NOT TEST LEFT
- 2 Right → DO NOT TEST RIGHT
- 3 Both → DO NOT TEST EITHER SIDE

GSFLAGEX

---

3 Right side

Trial 1 ☐☐ kg GSRT1
○ Refused
○ Unable, did not attempt

Trial 2 ☐☐ kg GSRT2
○ Refused
○ Unable, did not attempt

GSGRPRAV
GSGRPAVG
GSGRPMAX
GSGRPLAV

GS1S2AVS
GSDS2AVS
GSSS2AVS
GS2S2AVS
GS3S2AVS

4 Left side

Trial 1 ☐☐ kg GSLF1
○ Refused
○ Unable, did not attempt

Trial 2 ☐☐ kg GSLF2
○ Refused
○ Unable, did not attempt

GS1S2GSP
GSDS2GSP
GSSS2GSP
GS2S2GSP
GS3S2GSP

Version 1.0 07.08.2009
MrOSCQGripStrength
MrOS Sleep Visit 2

Mr. OS Sleep

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Chair Stands

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INTRODUCTION/SCREENING QUESTIONS

1 Ask the participant: **Do you use any walking aids, such as a cane?** NFAIDS
1○ No aids 2○ Cane or quad cane 3○ Walker, wheelchair, leg brace, crutches

2 Does the participant have any of the following? If you are uncertain about one of following conditions, ask the participant. (Mark all that apply)
1 NFORTH ○ Orthosis ○ Missing limbs 1 NFLIMB ○ Prosthesis 1 NFPROTHE ○ Paralysis of extremity or side of body 1 NFPARALY

3 Ask the participant: **Do you have any problems from recent surgery, injury or other health conditions that might prevent you from standing straight up from a chair or walking quickly?**

NFPROB 1○ Yes → 0○ No

Tell the participant: "Before we do each test, I'll describe it to you. Please tell me if you think that you shouldn't attempt the test because of the problems you described."

SINGLE CHAIR STAND

4 **Could the participant stand up one time unassisted?** NFSTAND1
1○ Yes 2○ No, unable to stand 3○ No, rises using arms 7○ Did not attempt/Refused

Do **NOT** perform Repeat Chair Stands. Go on to Six Meter Usual Pace

REPEATED CHAIR STANDS

5 **Did the participant complete all 5 stands?**

1○ Yes

Time to complete stands? NFTIME5 ___ . ___ **seconds**

Record arm use:
1○ Did not use arms
2○ Used arms part of the time
3○ Used arms all of the time

NFARMU5A

0○ No NF5STAND

How many chair stands were completed? NF5MANY ___ **stands**

Why weren't 5 chair stands completed?
4○ Attempted, but unable to stand once without help
5○ Completed at least 1 stand, but unable to complete 5 without help
7○ Did not attempt/refused NFARMU5B

NFSTDARM

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Walking Tests

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SIX METER USUAL PACE

1 **Did the participant complete Trial 1?** NFWLKNA1

1○ Yes 2○ No, participant attempted but unable 3○ No, unable to assess

NFSTPLGT
NFWLKSPD
NF6MWTM
NF6MPACE

Record time and number of steps: ____ . NFWLKTM1 seconds NFWLKST1 steps

Aid used: 0○ No aid 1○ Straight cane 2○ Quad cane 3○ Walker 4○ Crutch NFWLKAD1

NF1S26MT
NFDS26MT
NFSS26MT
NF2S26MT
NF3S26MT

2 **Did the participant complete Trial 2?**

1○ Yes 2○ No, participant attempted but unable 3○ No, unable to assess NFWLKNA2

NF1S26MP
NFDS26MP
NFSS26MP
NF2S26MP
NF3S26MP

Record time and number of steps: NFWLKTM2 . ____ seconds NFWLKST2 steps

Aid used: 0○ No aid 1○ Straight cane 2○ Quad cane 3○ Walker 4○ Crutch NFWLKAD2

NF1S2WKS
NFDS2WKS
NFSS2WKS
NF2S2WKS
NF3S2WKS

NFNWTIME
NFNWPACE
NFPCTDIF
NFDFSCOR
NFNWNUM

NARROW WALK

id the participant successfully stay within the lines on Trial 1 (have 2 or less deviations)?

1○ Yes 0○ No, 3 or more deviations/Unable to complete 2○ No, trial not attempted NFNWKNA1

Record time: NFNWKTM1 . ____ seconds **Aid used:** 0○ No aid NFNWLKA1 1○ Straight cane 2○ Quad cane 3○ Walker 4○ Crutch

NF1S2NWT
NFDS2NWT
NFSS2NWT
NF2S2NWT
NF3S2NWT

4 **Did the participant successfully stay within the lines on Trial 2 (have 2 or less deviations)?**

1○ Yes 0○ No, 3 or more deviations/Unable to complete 2○ No, trial not attempted NFNWKNA2

Record time: NFNWKTM2 . ____ seconds **Aid used:** 0○ No aid NFNWLKA2 1○ Straight cane 2○ Quad cane 3○ Walker 4○ Crutch

Perform trial 3 only if trial 1 or trial 2 were marked 'No, 3 or more deviations/Unable to complete'

NF1S2NWP
NFDS2NWP
NFSS2NWP
NF2S2NWP
NF3S2NWP

5 **Did the participant successfully stay within the lines on Trial 3 (have 2 or less deviations)?**

1○ Yes 0○ No, 3 or more deviations/Unable to complete 2○ No, trial not attempted NFNWKNA3

Record time: NFNWKTM3 . ____ seconds **Aid used:** 0○ No aid NFNWLKA3 1○ Straight cane 2○ Quad cane 3○ Walker 4○ Crutch

NF1S2PDF
NFDS2PDF
NFSS2PDF
NF2S2PDF
NF3S2PDF

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Blood Pressure & Pulse

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BLOOD PRESSURE

1 **Was first sitting blood pressure obtained?** 1○ Yes 0○ No BPBP

SITTING MEASUREMENT 1

Systolic ○ Systolic Error BPBPSYS **mmHg**

Diastolic ○ Diastolic Error BPBPDIA **mmHg**

2 **Was second sitting blood pressure obtained?** 1○ Yes 0○ No BPBP2

SITTING MEASUREMENT 2

Systolic ○ Systolic Error BPBPSYS2 **mmHg**

Diastolic ○ Diastolic Error BPBPDIA2 **mmHg**

3 **Cuff Size for BpTru:** 0○ Child 1○ Small 2○ Regular 3○ Large 5○ Extra Large BPTRCF

4 **Arm Used:** 1○ Right 2○ Left → Why wasn't right arm used: _____ BPARM

5 **Was an alert noted?** ○ Yes ○ No

Complete the Blood Pressure section on the Medical Alert Form

RADIAL PULSE

6 **Was Pulse Obtained?** 1○ Yes 0○ No HWPULSE

Measurement 1 HWPULSE1 **beats per minute**

Measurement 2 HWPULSE2 **beats per minute**

Total (Measurement 1 + Measurement 2) HWPULSET ÷ 2 = HWPULSEM **Average beats per minute**

Version 1.0 07.08.2009
MrOSCTBPPulse
MrOS Sleep Visit 2

Mr. OS Sleep

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Spirometry

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NOTE: Please ensure that the participant has not had any active respiratory symptoms (exacerbation, new cough, or wheezing), obvious respiratory distress, or recent onset of chest pains in the past two weeks. If so, please reschedule visit in two weeks.

1 SPIROMETRY EXCLUSION CRITERIA:

a. Have you had a heart attack, a stroke, or eye surgery in the past three months?
1○ Yes 0○ No SRHRTEYE
→ NOT ELIGIBLE

b. Do you have any of the following problems: coughing up blood; a past history of an air leak in your lungs; or past history of an aneurysm in your chest? 1○ Yes 0○ No SRHEMOPT
→ NOT ELIGIBLE

c. Have you had any significant problems doing spirometry in the past?
1○ Yes 0○ No 8○ Don't Know SRPROBLM
→ Please describe: _____
If the problem was indeed significant and likely to recur with retesting, participant is NOT ELIGIBLE. DO NOT PROCEED with spirometry measurements.

2 Did the participant complete the spirometry test? 1○ Yes 0○ No SRSPIRO VS2SR VS2SRRSN

Why not? 7○ Refused 0○ Not eligible 1○ Physical/Medical Problem 2○ Equipment Problem 3○ Other _____ SRWHYN

3 PRE-TEST:

a. Did you smoke within the last two hours? 1○ Yes 0○ No SRSMOKE2

b. Did you use an inhaled bronchodilator within the last four hours? 1○ Yes 0○ No SRBRONC4

c. Have you had a cold or minor respiratory illness (not listed above) in the last two weeks (i.e., sinus issue)? 1○ Yes 0○ No SRCOLD2W

d. Date of Birth: ☐☐ / ☐☐ / ☐☐☐☐ (Month / Day / Year)

e. Height: ☐☐☐ inches

f. Weight: ☐☐☐ lbs

4 POST-TEST:

a. Did any of the following occur during testing? (mark all that apply)

○ Headache 1 SRHACHE ○ Dizziness or lightheadedness 1 SRDIZZY ○ Coughing 1 SRCOUGH
○ Shortness of breath 1SRBREATH ○ Other _____ 1 SROTHER

b. How many manuevers were attempted? ☐ SRMNVRS manuevers

ECG

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Office Use Only-- MrOS ID#	Acrostic	ECSTAFF ECGStaff ID#

1 **Was an ECG obtained?** *1* ○ Yes *0* ○ No *ECECG*

Why not? *ECNOECG*

1 ○ Equipment failure
2 ○ Participant unable to understand instructions
3 ○ Participant unable to physically cooperate
4 ○ Participant refused
5 ○ Other _____

2 **Was an alert noted?** ○ Yes ○ No

Complete the ECG section on the Medical Alert Form

Draft

Blood Collection & Processing

Office Use Only--
MrOS ID# | **Acrostic** | **Staff ID#**

1 **Was any blood drawn?** ○ Yes ○ No

2 **Was a fasting sample collected?** *1* ○ Yes *0* ○ No *SCFAST*

3 **Time of last meal:** ☐☐ : ☐☐ **Hours** **Minutes** ○ am ○ pm

4 **Time of blood draw:** ☐☐ : ☐☐ **Hours** **Minutes** ○ am ○ pm

5 **Date of Lab Processing:** ☐☐ / ☐☐ / ☐☐☐☐ **Month** **Day** **Year**

Vial #1:(Clear/1.0 mL serum) ○ Complete ○ Hemolyzed ○ Partial ○ Hemolyzed/partial ○ Not filled

Vial #2:(Clear/1.0 mL serum) ○ Complete ○ Hemolyzed ○ Partial ○ Hemolyzed/partial ○ Not filled

Vial #3:(Clear/1.0 mL serum) ○ Complete ○ Hemolyzed ○ Partial ○ Hemolyzed/partial ○ Not filled

Vial #4:(Clear/1.0 mL serum) ○ Complete ○ Hemolyzed ○ Partial ○ Hemolyzed/partial ○ Not filled

6 **Ending time of laboratory processing:** ☐☐ : ☐☐ **Hours** **Minutes** ○ am ○ pm

7 **Enter ID from bar code label:** ☐☐☐☐☐☐

Affix bar code label:

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Urine Collection & Processing

Office Use Only--
MrOS ID# | Acrostic | Staff ID#

1 **Was urine collected?** ○ Yes ○ No

A. Date of specimen collection: ☐☐ / ☐☐ / ☐☐☐☐ (Month / Day / Year)

B. Was a fasting sample collected? 1 ○ Yes 0 ○ No
SCUFAST

C. Time of last meal: ☐☐ : ☐☐ ○ am ○ pm

D. Time participant collected specimen: ☐☐ (Hours) : ☐☐ (Minutes) ○ am ○ pm

E. What void was this? ○ 1st ○ 2nd ○ >2nd

Date of Lab Processing: ☐☐ / ☐☐ / ☐☐☐☐ (Month / Day / Year)

Start time of lab processing: ☐☐ (Hours) : ☐☐ (Minutes) ○ am ○ pm

Vial #5:(Yellow/4.0mL urine) ○ Complete ○ Partial ○ Not filled

Vial #6:(Yellow/4.0mL urine) ○ Complete ○ Partial ○ Not filled

Enter ID from bar code label: ☐☐☐☐☐☐

Version 1.0 07.08.2009
MrOSCXUrine
MrOS Sleep Visit 2

Mr. OS Sleep

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Page 22: DXA Form data are not released due to the scan data not being centrally processed for this visit.

Draft

Nottingham Power Rig

Office Use Only-
MrOS ID# | Acrostic | Staff ID# NPSTAFF

1 **Have you had a hip replaced in the last six months?**

1○ Yes 0○ No NPHIPREP

Which side have you had replaced? NPHIPSD

1○ Left (Do not test left side) 2○ Right (Do not test right side) 3○ Both (Do not test either side)

2 **Was the testing done on the RIGHT side?**

1○ Yes 0○ No NPRGTB

Why not? NPRGTBR
- 1○ Machine failure
- 2○ Refused
- 3○ Unable due to physical limitation

Record seat position used while testing to the nearest centimeter: NPSEATR . NP5CMDR cm

Is this distance within 5cm of the seat position from the most recent MrOS visit? 1○ Yes 0○ No

Why not? _____

NP1S2RM NPDS2RM NP2S2RM NP3S2RM NP1S2LM NPDS2LM NP2S2LM NP3S2LM NP1S2OM NPDS2OM NP2S2OM NP3S2OM

1 ___.___ NPRIGHT1 watts
2 ___.___ NPRIGHT2 watts
3 ___.___ NPRIGHT3 watts
4 ___.___ NPRIGHT4 watts
5 ___.___ NPRIGHT5 watts

Was the testing done on the LEFT side?

1○ Yes 0○ No NPLFTB

Why not? NPLFTBR
- 1○ Machine failure
- 2○ Refused
- 3○ Unable due to physical limitation

Record seat position used while testing to the nearest centimeter. NPSEATL . NP5CMDL cm

Is this distance within 5cm of the seat position from the most recent MrOS visit? 1○ Yes 0○ No

Why not? _____

NP1S2RMP NP1S2LMP NP1S2OMP NPDS2RMP NPDS2LMP NPDS2OMP NP2S2RMP NP2S2LMP NP2S2OMP NP3S2RMP NP3S2LMP NP3S2OMP

1 ___.___ NPLEFT1 watts
2 ___.___ NPLEFT2 watts
3 ___.___ NPLEFT3 watts
4 ___.___ NPLEFT4 watts
5 ___.___ NPLEFT5 watts

NPRMAX NPLMAX NPOMAX

NPABLEB NPABLEL NPABLER NPBTHBR

Draft

Actigraphy Checklist

Office Use Only--
MrOS ID# | **Acrostic** | **Staff ID#**

1 **Did the participant receive an actigraph?** ○ Yes ○ No

VS2ACTIG
VS2ACTRSN

Watch Serial Number:

What arm was watch worn on?
(should be non-dominant when possible)

- ○ Left, non-dominant
- ○ Left, dominant
- ○ Right, non-dominant
- ○ Right, dominant

Why not?

- ○ Refused
- ○ Cognitive Impairment
- ○ Physical/Medical Problem
- ○ No watch available/Schedule problem
- ○ Oxygen Use
- ○ Defibrillator
- ○ Other _____

2 **Date watch given to participant** ___ / ___ / ___
Month Day Year

3 **Date watch returned to clinic** ___ / ___ / ___
Month Day Year

4 **How many nights were watch data collected? (record number of nights in .aw5 file)** ___ **nights**

If less than 3 nights, will participant rewear the watch? ○ Yes ○ No

5 **Was the sleep diary completed?** ○ Yes ○ No

Why not? ○ Refused ○ Unable

Was the diary completed accurately for all days and all sections? ○ Yes ○ No

Please indicate which sections were not accurately completed for ALL days (mark all that apply):

- ○ Napping Information
- ○ Removal times information
- ○ Still times information
- ○ Bed time and wake time information

Draft

PSG Checklist

Office Use Only-- MrOS ID#	Acrostic	Staff ID#
		POSTAFF

1 **Did the participant complete the PSG measurement?** 1 ○ Yes 0 ○ No POCOMP

VS2PSG
VS2PSGRSN

Why not?
7 ○ Refused POWHYN
2 ○ Physical/Medical Problem
3 ○ No equipment available
4 ○ Other _____

2 **Date of overnight PSG:** ☐☐ / ☐☐ / ☐☐☐☐ PODATE
Month Day Year

3 **Safiro ID:** ☐☐☐☐ POPSGID

4 **Please record the following levels from the time of signal verificaiton.**

SaO2 level: ☐☐☐ % POBASESAT **Heart rate:** ☐☐☐ **beats per minute** POBASEHRT

5 **Did the participant use oxygen the night of the psg study?** 1 ○ Yes 0 ○ No POOXYG

6 **Did the participant use CPAP or BiPAP the night of the psg study?** 1 ○ Yes 0 ○ No POCPAP

7 **Did the participant use a mouthpiece (for snoring) the night of the psg study?** 1 ○ Yes 0 ○ No POMOUTH

8 **Was the PSG morning survey completed?** 1 ○ Yes 0 ○ No POSURV

Why not? 7 ○ Refused 8 ○ Unable POSURVN

Draft

PSG Morning Survey

Date of PSG: ☐☐ / ☐☐ / ☐☐☐☐

Office Use Only--
MrOS ID# ☐☐☐☐☐☐ **Acrostic** ☐☐☐☐ **Staff ID#** ☐☐☐☐

---

1 **What time did you go to bed (lay down and turn off the lights) last night?** POXBEDTM ☐☐ : ☐☐ ○ A.M. ○ P.M.

2 **What time did you wake up today?** POXWKTM ☐☐ : ☐☐ ○ A.M. ○ P.M.

3 **How much time do you think you actually slept last night?** POXSLPMN ☐☐ **hours** ☐☐ **minutes**

4 **What time did you collect your urine?** POXURITM ☐☐ : ☐☐ ○ A.M. ○ P.M.

5 **Rate the quality of your sleep last night. Do not compare to usual sleep quality. My sleep last night was (mark a number for each)...**

a. **LIGHT** POXQUAL1 **DEEP**
○ 1 ○ 2 ○ 3 ○ 4 ○ 5

b. **SHORT** POXQUAL2 **LONG**
○ 1 ○ 2 ○ 3 ○ 4 ○ 5

c. **RESTLESS** POXQUAL3 **RESTFUL**
○ 1 ○ 2 ○ 3 ○ 4 ○ 5

6 **Compared to your usual night's sleep, how well did you sleep last night?**

POXUSUAL
1 ○ Much worse than usual
2 ○ Somewhat worse than usual
3 ○ As well as usual
4 ○ A little better than usual
5 ○ Much better than usual

7 **How long did it take you to fall asleep at bedtime last night?** POXFALL ☐☐ **hours** ☐☐ **minutes**

8 **What was your sleeping arrangement LAST NIGHT?** POXSLARR

1 ○ Another person in same bed
2 ○ Another person in same room, but different bed
3 ○ Alone in room

9 **What is your USUAL sleeping arrangement?** POXSLUS

1 ○ Another person in same bed
2 ○ Another person in same room, but different bed
3 ○ Alone in room

POXCAF
POXDRNK
Draft

PSG Morning Survey

Office Use Only--
MrOS ID# | | | | | | | |

○ MISSING
Acrostic | | | | |

For questions 10-11, please think back to the 4 hour period before you went to sleep <u>LAST NIGHT</u>.

10 How many of the following drinks did you have during the 4 hours before you went to sleep last night? Please write '0' if you did not drink any of that beverage.

a. | | glasses of wine (4 oz.) POXWINE

b. | | drinks with hard liquor (1 shot) POXLIO

c. | | bottles or cans of beer (12 oz.) POXBEER

d. | | cups of regular coffee (with caffeine) POXCOFF

e. | | cups of tea (with caffeine) POXTEA

f. | | glasses or cans of cola or other soda (with caffeine) POXSODA

11 How much did you smoke during the 4 hours before you went to sleep last night? Please write '0' for each that you did not smoke last night.

a. | | number of cigarettes POXCIG

b. | | number of pipe bowls POXPIPE

c. | | number of cigars POXCIGAR

12 Did you have nasal stuffiness, obstruction, or discharge last night? 1○ Yes 0○ No POXNASAL

Did this interfere with your sleep last night? 1○ Yes 0○ No POXINTER

13 During the PAST MONTH, how often have you had trouble sleeping because of...

		Not During the Past Month 0	Less than Once a Week 1	Once or Twice a Week 2	Three or More Times a Week 3
a. Coughing	POXCOUGH	○	○	○	○
b. Snorting or gasping	POXSNORT	○	○	○	○
c. Chest pain or discomfort	POXCPAIN	○	○	○	○
d. Shortness of breath	POXSBRE	○	○	○	○
e. Nasal stuffiness	POXSTUFF	○	○	○	○
f. Heart burn or reflux	POXHBURN	○	○	○	○
g. Leg jerks or kicks	POXLEGK	○	○	○	○

14 a. Do you have air conditioning? 1○ Yes 0○ No POXAC

LAST NIGHT, did you use air conditioning? 1○ Yes 0○ No POXACUSE

b. LAST NIGHT, were your windows open? 1○ Yes 0○ No POXWIN

Draft