



PVDOMICS STUDY
Participant Sleep Study Questionnaire - Form #151

Instructions: Please provide us with information about the night you wore the sleep device. Record your information in the blanks provided below.

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1. Identification Number				

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2. Alphacode

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3. Start date when device placed: (mm/dd/yyyy)

4. a. What time did you start putting on the device? :
hour minutes
- b. Circle one: (1)AM (2)PM
5. a. What time did you go to bed last night? :
(time the lights were turned off) hour minutes
- b. Circle one: (1)AM (2)PM
6. a. What time did you fall asleep last night? :
hour minutes
- b. Circle one: (1)AM (2)PM
7. a. What time did you get up this morning? :
hour minutes
- b. Circle one: (1)AM (2)PM
8. How many times did you wake up last night? :
9. How many times did you get out of bed? :
(for example: to use the bathroom)
10. While you were sleeping:
- a. Did you wear oxygen?..... Circle one: (0)No (1)Yes
- b. Did you wear PAP sleeping device? Circle one: (0)No (1)Yes
- c. Did you wear other prescribed sleeping device? Circle one: (0)No (1)Yes
(if yes, what was device: _____)

--Please turn this page over to answer the following questions.--

11. Did any of the following items cause you any discomfort or fall off during the night?

For each question, circle the answer(s) that apply.

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|---------------------------------|-------|---------------|-------------|
| a. Belt around your chest?..... | (0)No | (1)Discomfort | (2)Fell Off |
| b. Belt around your waist?..... | (0)No | (1)Discomfort | (2)Fell Off |
| c. Tubing in your nose?..... | (0)No | (1)Discomfort | (2)Fell Off |
| d. Finger / wrist device? | (0)No | (1)Discomfort | (2)Fell Off |
| e. Sticky ECG pads?..... | (0)No | (1)Discomfort | (2)Fell Off |

Please return this completed questionnaire to your PVDOMICS Study Coordinator along with the sleep monitoring device.

Thank you.

This section is completed by the PVDOMICS Study Staff:

200. Date form reviewed (mm/dd/yyyy) ____/____/____

201. Username of person completing/reviewing completeness of this form....._____

Clinical Center Use Only

Date Form Entered (mm/dd/yyyy) ____/____/____

Username of person entering this form_____