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Participant ID Nickname

Restoring Insulin Secretion Study
BERLIN SLEEP QUESTIONNAIRE

Height (m) _____ Weight (kg) _____ Age _____ Male / Female

***Instructions*: Please choose the correct response to each question.**

CATEGORY 1

1. Do you snore?
   - □ a. Yes
   - □ b. No
   - □ c. Don't know

If you snore:

2. Your snoring is:
   - □ a. Slightly louder than breathing
   - □ b. As loud as talking
   - □ c. Louder than talking
   - □ d. Very loud – can be heard in adjacent rooms

3. How often do you snore?
   - □ a. Nearly every day
   - □ b. 3-4 times a week
   - □ c. 1-2 times a week
   - □ d. 1-2 times a month
   - □ e. Never or nearly never

4. Has your snoring ever bothered other people?
   - □ a. Yes
   - □ b. No
   - □ c. Don't know

5. Has anyone noticed that you quit breathing during your sleep?
   - □ a. Nearly every day
   - □ b. 3-4 times a week
   - □ c. 1-2 times a week
   - □ d. 1-2 times a month
   - □ e. Never or nearly never

CATEGORY 2

6. How often do you feel tired or fatigued after your sleep?
   - □ a. Nearly every day
   - □ b. 3-4 times a week
   - □ c. 1-2 times a week
   - □ d. 1-2 times a month
   - □ e. Never or nearly never

7. During your waking time, do you feel tired, fatigued or not up to par?
   - □ a. Nearly every day
   - □ b. 3-4 times a week
   - □ c. 1-2 times a week
   - □ d. 1-2 times a month
   - □ e. Never or nearly never

8. Have you ever nodded off or fallen asleep while driving a vehicle?
   - □ a. Yes
   - □ b. No

If yes:

9. How often does this occur?
   - □ a. Nearly every day
   - □ b. 3-4 times a week
   - □ c. 1-2 times a week
   - □ d. 1-2 times a month
   - □ e. Never or nearly never

CATEGORY 3

10. Do you have high blood pressure?
    - □ a. Yes
    - □ b. No
    - □ c. Don't know

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Participant ID Nickname

Restoring Insulin Secretion Study
Epworth Sleepiness Scale

Age: _____ Male/Female

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 work out how they would have affected you. Use the following scale to choose the *most appropriate number* for each situation:

0 = no chance of dozing
1 = slight chance of dozing
2 = moderate chance of dozing
3 = high chance of dozing

SITUATION	**CHANCE OF DOZING (From 0 to 3)**
Sitting and reading	_____
Watching TV	_____
Sitting inactive in a public place (e.g. a theater or a meeting)	_____
As a passenger in a car for an hour without a break	_____
Lying down to rest in the afternoon when circumstances permit	_____
Sitting and talking to someone	_____
Sitting quietly after a lunch without alcohol	_____
In a car, while stopped for a few minutes in traffic	_____

Participant ID _____ Nickname _____

Restoring Insulin Secretion Study
PITTSBURGH SLEEP QUALITY INDEX (PSQI)

Age _____

Instructions:
The following questions 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. Please answer all questions.

1. Are you currently employed or self-employed? Yes _____ No _____

If you answered **YES** please answer the questions on this page. If you answered **NO** please go to next page.

2. During the past month, when have you usually gone to bed at night?

Usual Bed Time on WORK DAYS _____

Usual Bed Time on DAYS OFF WORK_____

3. During the past month, how long (in minutes) has it usually taken you to fall asleep each night?

NUMBER OF MINUTES _____

4.a. During the past month, when have you usually gotten up in the morning?

Usual GETTING UP Time on WORK DAYS _____

Usual GETTING UP Time on DAYS OFF WORK_____

4.b. During the past month, how many hours of *actual sleep* did you get at night on WORK DAYS and DAYS OFF WORK? (This may be different than the number of hours you spend in bed.)

WORK DAYS Hours of Sleep per Night _____

DAYS OFF WORK Hours of Sleep per Night _____

4.c. How many days do you work in a TYPICAL week? _____ days

4.d. Does your CURRENT job involve the following conditions (check as many as apply to you):

Working overnight shifts: Yes_____ No_____

Starting work before 6 AM: Yes_____ No_____

Rotating night and day shifts: Yes_____ No_____

4.e. If you could get as much sleep as you wanted in one night, how much sleep would you prefer to get?

PREFERED HOURS OF SLEEP PER NIGHT _____

PLEASE GO TO PAGE 3 AND START WITH QUESTION # 5.

Instructions:
The following questions 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. Please answer all questions.

If you are currently NOT employed or NOT self-employed please answer the following questions:

A.1. During the past month, when have you usually gone to bed at night?

Usual WEEKDAY Bed Time _____

Usual WEEKEND Bed Time _____

A.2. During the past month, how long (in minutes) has it usually taken you to fall asleep each night?

NUMBER OF MINUTES _____

A.3. During the past month, when have you usually gotten up in the morning?

Usual WEEKDAY Getting Up Time _____

Usual WEEKEND Getting Up Time _____

A.4. During the past month, how many hours of actual sleep did you get at night on weekdays and weekends? (This may be different than the number of hours you spend in bed.)

WEEKDAY Hours of Sleep per Night _____

WEEKEND Hours of Sleep per Night _____

A.4.1. If you could get as much sleep as you wanted in one night, how much sleep would you prefer to get?

HOURS OF SLEEP PER NIGHT _____

PLEASE GO TO PAGE 3 AND START WITH QUESTION # 5.

PLEASE ANSWER QUESTIONS 5 to 10 WHETHER YOU WORK OR NOT:

For each of the remaining questions, check the one best response. Please answer *all* questions.

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

(a) Cannot get to sleep within 30 minutes

Not during the past month_____ Less than once a week_____ Once or twice a week_____ Three or more times a week_____

(b) Wake up in the middle of the night or early morning

Not during the past month_____ Less than once a week_____ Once or twice a week_____ Three or more times a week_____

(c) Have to get up to use the bathroom

Not during the past month_____ Less than once a week_____ Once or twice a week_____ Three or more times a week_____

(d) Cannot breathe comfortably

Not during the past month_____ Less than once a week_____ Once or twice a week_____ Three or more times a week_____

(e) Cough or snore loudly

Not during the past month_____ Less than once a week_____ Once or twice a week_____ Three or more times a week_____

(f) Feel too cold

Not during the past month_____ Less than once a week_____ Once or twice a week_____ Three or more times a week_____

(g) Feel too hot

Not during the past month_____ Less than once a week_____ Once or twice a week_____ Three or more times a week_____

(h) Had bad dreams

Not during the past month_____ Less than once a week_____ Once or twice a week_____ Three or more times a week_____

(i) Have pain

Not during the past month_____ Less than once a week_____ Once or twice a week_____ Three or more times a week_____

(j) Other reason(s), please describe _____

_____

How often during the past month have you had trouble sleeping because of this?

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 would you rate your sleep quality overall?

Very good	_____
Fairly good	_____
Fairly bad	_____
Very bad	_____

7. During the past month, how often have you taken medicine (prescribed or "over the counter") to help you sleep?

Not during the past month_____	Less than once a week_____	Once or twice a week_____	Three or more times a week_____

8. During the past month, how often have you had trouble staying awake while driving, eating meals, or engaging in social activity?

Not during the past month_____	Less than once a week_____	Once or twice a week_____	Three or more times a week_____

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

No problem at all	_____
Only a very slight problem	_____
Somewhat of a problem	_____
A very big problem	_____

10. Do you have a bed partner or roommate?

No bed partner or roommate	_____
Partner/roommate in other room	_____
Partner in same room, but not same bed	_____
Partner in same bed	_____

If you have a roommate or bed partner, ask him/her how often in the past month you have had…

(a) Loud snoring

Not during the past month_____	Less than once a week_____	Once or twice a week_____	Three or more times a week_____

(b) Long pauses between breaths while asleep

Not during the past month_____	Less than once a week_____	Once or twice a week_____	Three or more times a week_____

(c) Legs twitching or jerking while asleep

Not during the past month_____	Less than once a week_____	Once or twice a week_____	Three or more times a week_____

(d) Episodes of disorientation or confusion during sleep

Not during the past month_____	Less than once a week_____	Once or twice a week_____	Three or more times a week_____

(e) Other restlessness while you sleep; please describe _____

_____

Not during the past month_____	Less than once a week_____	Once or twice a week_____	Three or more times a week_____