For Administrator Use Only	Date (dd/mm/yy):	Subject #:

Health and Demographic Questionnaire

Please fill out this form as accurately as possible and return it to the experimenter

1. Basic Demographic Information

Date of Birth (month/year): _____ Age: _____

Weight: _____ Height: _____

Handedness: _____

First language: _____ Other languages: _____

Level of Education and total years (e.g. 4 years high school, 4 years university, etc.)

_____

Occupation: _____

2. Health-Related Information

A. Smoking History (please circle): Never Smoker Ex-Smoker Current Smoker

If current smoker, indicate how many years and how many cig/day: _____

If ex-smoker, indicate year that you quit; how many years smoking; how many cig/day:

_____

B. Alcohol History

Average number of drinks per week: _____

Has there ever been heavy alcohol consumption? (please circle) Yes No

If yes, when, for how long, and estimate your weekly alcohol consumption during that time: _____

C. Exercise

How many times per week do you exercise? _____

When you exercise, how long (in minutes) is each session? _____

What kind of exercise do you do? (list all types) _____

_____

D. Eye Glasses (only if applicable)

What is the prescription of your eye glasses? _____

Without the aid of glasses are you able to see near objects well (please circle)?

Yes No

Without the aid of glasses are you able to see far objects well (please circle)?

Yes No

E. Hearing Assistance (only if applicable)

Do you have any hearing impairments? If yes, which ear(s)? _____

Do you wear a hearing aid? If yes, which ear(s)? _____

F. Parkinson's Disease (only if applicable)

What year were you diagnosed with Parkinson's disease? _____

Which side of the body is more affected? _____

G. Social Activity

Do you belong to a social group (circle one)? Yes No

If yes, please list the types of social groups to which you belong and how often they meet per week: _____

_____

H. Cognitive Impairment

Have you been diagnosed with a cognitive impairment (MCI, Dementia, Alzheimer's Disease, etc)? (please circle one) Yes No

If yes, what is your diagnosis? _____

When were you diagnosed? _____

Sleep Quality Assessment

During the past month:

When have you usually gone to bed? _____

How long (in minutes) has it taken you to fall asleep each night? _____

What time have you usually gotten up in the morning? _____

How many hours of actual sleep did you get at night? _____

How many hours were you in bed? _____

During the past month, how often have you had trouble sleeping because you	**Not during the past month**	**Less than once a week**	**Once or twice a week**	**Three or more times a week**
Cannot get to sleep within 30 mins				
Wake up in the middle of the night or early morning				
Have to get up to use the bathroom				
Cannot breath comfortably				
Cough or snore loudly				
Feel too cold				
Feel to hot				
Have bad dreams				
Have Pain				
Other reason? Please describe:				
During the past month, how often have you taken medication (prescribed or “over the counter”) to help you sleep?				
During the past month, how often have you had trouble staying awake while driving, eating meals or engaging in social activity?				
During the past month, how much of a problem has it been for you to keep up enthusiasm to get things done?				
During the past month, how would you rate your sleep quality overall?	Very Good	Fairly Good	Fairly Bad	Very Bad

3. Previous Medical Problems

Have you had any major health problems or do you have any chronic, ongoing medical conditions such as high blood pressure, high cholesterol, diabetes, thyroid problems, multiple sclerosis or epilepsy?

Have you had any strokes, heart attacks/ heart surgeries, significant head trauma, or cancer? If you've had cancer, what kind and what treatments did you receive (e.g. chemotherapy)?

Have you ever had more than one seizure? Answer in the space below.

4. Current Medication

Please list any medications you are currently taking, what they are treating for specifically, and the prescribed dosage.