Sleep Quality Across the Medical Career Continuum: A Cross- Sectional Study - Case Report Form					
Participant Group			**Internal medicine resident**		
			Surgical resident		
			Preclinical medical student		
			Clinical medical student		
			Intern medical student		
			Control group		
Participant ID:					
Age:	**Height:**		**Weight:**		
Sex			**Female**		
			Male		
Place of Residence			**Student dormitory**		
			Own residence		
			Family home		
Do you smoke?			**Yes**		
			No		
If yes, please specify:	**For how many years have you been smoking?**		**How many packs do you smoke per day?**		
Do you consume alcohol?			**Yes**		
			No		
If yes, how frequently do you consume alcohol?	**Daily**	**Every other day**		**Once a week**	**Once a month**
Do you consume caffeinated beverages?			**Yes**		
			No		
If yes, please indicate the appropriate amount:			**I drink …… cups of coffee per day.**		
			I drink …… cups of tea per day.		
			I drink …… servings of carbonated beverages per day.		

How many on-call shifts do you undertake per month?		
Do you take post-call leave after an on-call shift?	**Yes**	
	No	
Do you have a habit of eating before bedtime?	**Yes**	
	No	
Do you exercise regularly?	**Yes**	
	No	

If yes, how frequently do you exercise?	**Less than 3 days per week**	**More than 3 days per week**

How many hours do you sleep on average per day?	**Less than 6 hours**	**6–9 hours**	**More than 9 hours**

Duration of screen use before bedtime, including phone, tablet, computer, or television:	**I do not use any screen**	**0–30 minutes**	**30–60 minutes**	**More than 1 hour**

Duration of screen use in bed while preparing to sleep, including phone, tablet, computer, or television:	**I do not use any screen**	**0–30 minutes**	**30–60 minutes**	**More than 1 hour**

Epworth Sleepiness Scale				
	Would never doze, 0 points	**Slight chance of dozing, 1 point**	**Moderate chance of dozing, 2 points**	**High chance of dozing, 3 points**
Sitting and reading a newspaper or book				
Sitting inactive in a public place, such as a theatre or meeting				
During a conversation				
After lunch				
Watching television				
Resting in the afternoon				
As a passenger in a car for less than one hour				
While stopped in traffic while driving				
Total score:				

Pittsburgh Sleep Quality Index

The following questions refer to your sleep habits during the past one month. Please answer all questions with reference to the past month.

1.	During the past month, what time did you usually go to bed at night?	
2.	During the past month, how long did it usually take you to fall asleep at night, in minutes?	
3.	During the past month, what time did you usually get up in the morning?	
4.	During the past month, how many hours of actual sleep did you get at night? This may be different from the number of hours you spent in bed.	

During the past month, how often have you experienced the following sleep problems?

		Not during the past month	Less than once a week	Once or twice a week	Three or more times a week
5a	Could not fall asleep within 30 minutes				
5b	Woke up in the middle of the night or early morning				
5c	Had to get up to use the bathroom				
5d	Could not breathe comfortably				
5e	Coughed or snored loudly				
5f	Felt too cold				
5g	Felt too hot				
5h	Had bad dreams				
5i	Had pain				
5j	Other reason(s)				

		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 medication to help you sleep?				
7	During the past month, how often have you had trouble staying awake while driving, eating, or engaging in social activity?				
8	During the past month, how much of a problem has it been for you to maintain sufficient enthusiasm to get things done?				

		Very good	Fairly good	Fairly bad	Very bad
9	During the past month, how would you rate your overall sleep quality?				

Perceived Stress Scale

		Never	Almost never	Sometimes	Fairly often	Very often
1	In the past month, how often have you been upset because of something that happened unexpectedly?	0	1	2	3	4
2	In the past month, how often have you felt that you were unable to control the important things in your life?	0	1	2	3	4
3	In the past month, how often have you felt nervous and stressed?	0	1	2	3	4
4	In the past month, how often have you dealt successfully with irritating life hassles?	4	3	2	1	0
5	In the past month, how often have you felt that you were effectively coping with important changes occurring in your life?	4	3	2	1	0
6	In the past month, how often have you felt confident about your ability to handle your personal problems?	4	3	2	1	0
7	In the past month, how often have you felt that things were going your way?	4	3	2	1	0
8	In the past month, how often have you found that you could not cope with all the things that you had to do?	0	1	2	3	4
9	In the past month, how often have you been able to control irritations in your life?	4	3	2	1	0
10	In the past month, how often have you felt that you were on top of things?	4	3	2	1	0
11	In the past month, how often have you been angered because of things that were outside your control?	0	1	2	3	4
12	In the past month, how often have you found yourself thinking about things that you have to accomplish?	0	1	2	3	4
13	In the past month, how often have you been able to control the way you spend your time?	4	3	2	1	0
14	In the past month, how often have you felt difficulties were piling up so high that you could not overcome them?	0	1	2	3	4
TOTAL SCORE						