



Boston College daily sleep and well-being survey data during early phase of the COVID-19 pandemic

Citation

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COVID19 Short Version

Your health and safety are our number one priority. If diagnosed with COVID-19, we hope and encourage you to seek the treatment and care that you need and recover quickly. Any information that you provide us moving forward will be useful in understanding the effects of COVID-19 and the culture of living through a pandemic, but please do not let keeping up with these surveys interfere with your care in any way. Feel free to only respond to the study on days that you are feeling up to it.

If you are feeling up to it today, please take a few minutes to fill out this form at your earliest possible convenience, while the information is still fresh in your memory.

Subject ID

(Provided to you in initial email with link to demographic survey)

Today's Date (Click 'Now')

Last Night's Sleep

For questions asking about time, please use military time. For assistance, you may open the attachment or copy and paste this link into a new tab: <https://bit.ly/2HG8yuk>

What time did you get into bed last night?

What time did you try to fall asleep last night?

How long did it take you to fall asleep last night (in minutes)?

Approximately how many times did you wake up during the night last night?

- 0
 1
 2
 3
 4
 5 or more times

In total, how long were you up during the night due to these awakenings (in minutes)?

What time did you wake up this morning?

What time did you get out of bed this morning?

Did you dream last night?

- Yes
 No
 I don't recall

Please describe in as much detail as you'd like the content of your dreams last night.

Did you take a nap yesterday?

- Yes
 No

How many minutes was your nap yesterday?

Were the values reported here influenced/assisted by a sleep tracker of any kind (e.g. Fitbit, Apple Watch, etc)?

- Yes
 No

Feel free to include any other relevant information about your sleep here, including any disturbances that contributed to you waking up during the night.

Yesterday's Activity

Do you have a step counter?

- Yes
 No

If yes, please record the number of steps you took yesterday.

Did you leave your house yesterday?

- Yes
 No

What places did you visit outside of your home yesterday?

Outside of the people that you live with, approximately how many people did you come into face-to-face contact with yesterday?

(Within "social distance" of 6ft or 2 meters)

Did you do anything to socialize virtually or via phone with family or friends?

- Yes
 No

How much time did you spend socializing virtually or via phone (in minutes)?

Did you exercise for 20 minutes or more yesterday?

- No
 Yes, in the morning
 Yes, in the afternoon
 Yes, in the evening

How many alcoholic beverages did you consume yesterday?

Coronavirus Status

Are you in quarantine? Yes
 No

How many days have you been in quarantine? _____

Are you experiencing a fever? Yes
 No

How severe has your fever been over the last 24 hours?

	Mild				Moderate			Severe
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

What was your last recorded temperature? _____

Temperature Units Celsius
 Fahrenheit

Are you experiencing any respiratory symptoms? Yes
 No
(e.g. coughing, difficulty breathing)

If yes, please describe _____

How severe have your respiratory symptoms been over the last 24 hours?

	Mild				Moderate			Severe
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Have you been tested for COVID-19 (i.e. coronavirus)? Yes
 No

Have you been diagnosed with COVID-19 (i.e. coronavirus)? Yes
 No

As a reminder, for confidentiality purposes we are not tracking your responses in real time, nor are we using your responses to generate any diagnoses. If experiencing any symptoms, please be sure to follow guidelines of medical professionals and seek appropriate treatment as needed.

How stressed do you currently feel overall?

	Completely consumed by stress							Not stressed at all
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Please let us know anything else you feel like sharing about the last 24 hours.

(This information is confidential and will not be tracked in real time. Should you have any questions or technical concerns, please email study staff.)