FOLLOW-UP VISIT PACKET NACC UNIFORM DATA SET (UDS) **LBD MODULE**

Form B6L: Mayo Sleep Questionnaire — Participant

ADC name: _____ Subject ID: _ _ _ _ _ _ _ _ _ _ Form date: _ _ / _ _ / _ _ _ _

Visit #: _ _ _ Examiner's initials: _ _ _

INSTRUCTIONS: This form is to be completed by a clinician or other trained health professional based on the participant's response. For additional clarification and examples, see LBD Module Coding Guidebook for Follow-up Visit Packet, Form B6L. Check only one box

FOR CLINICIAN USE ONLY

0. Is the participant too cognitively impaired (e.g., CDR>1) to complete this form?

☐ 0 No **(CONTINUE TO ADMINISTER QUESTIONNAIRE)**

☐ 1 Yes **(END FORM HERE)**

Please mark "Yes" if the described event has occurred <u>at least 3 times</u>.

1. **Have you ever been told that you seem to "act out your dreams" while sleeping (punched or flailed arms in the air, shouted or screamed)?**	☐ 0 No **(SKIP TO QUESTION 2)** ☐ 1 Yes **(COMPLETE QUESTIONS 1a – 1e)**
1a. **How many months or years has this been going on?**	_ _ year(s) _ _ month(s)
1b. **Have you ever been injured from these behavior (bruises, cuts, broken bones)?**	☐ 0 No ☐ 1 Yes
1c. **Has a bedpartner ever been injured from these behaviors (bruises, blows, pulled hair)?**	☐ 0 No ☐ 1 Yes ☐ 8 No bedpartner
1d. **Have you had dreams of being chased or attacked, or that involve defending yourself?**	☐ 0 No ☐ 1 Yes
1e. **Have you been told that you make movements while sleeping that seem to match the details of your dream?**	☐ 0 No ☐ 1 Yes

2. **Have you been told that your legs repeatedly jerk or twitch during sleep (not just when falling asleep)?**	☐ 0 No ☐ 1 Yes
3. **Does a restless, nervous, tingly, or creepy-crawly feeling in your legs make it hard to fall or stay asleep?**	☐ 0 No **(SKIP TO QUESTION 4)** ☐ 1 Yes **(COMPLETE QUESTIONS 3a – 3c)**
3a. **Do you experience an irresistible urge to move the legs at those times?**	☐ 0 No ☐ 1 Yes
3b. **Do the uncomfortable leg sensations decrease when you move them or when you walk around?**	☐ 0 No ☐ 1 Yes
3c. **When do these sensations seem to be worse?**	☐ 1 Before 6:00 p.m. ☐ 2 After 6:00 p.m.
4. **Have you ever walked around the bedroom or house in your sleep?**	☐ 0 No ☐ 1 Yes
5. **Have you ever snorted or choked yourself awake?**	☐ 0 No ☐ 1 Yes
6. **Have you ever been told that you stop breathing in your sleep?**	☐ 0 No **(SKIP TO QUESTION 7)** ☐ 1 Yes **(COMPLETE QUESTION 6a)**
6a. **Are you currently being treated for this (e.g., CPAP)?**	☐ 0 No ☐ 1 Yes
7. **Do you experience leg cramps at night (e.g., also called a "charlie horse" with intense pain in certain muscles in the leg)?**	☐ 0 No ☐ 1 Yes
8. **Rate your general level of alertness for the past 3 weeks on a scale from 0 to 10:** ___ ___ 0 — 1 — 2 — 3 — 4 — 5 — 6 — 7 — 8 — 9 — 10 Sleep all day … Fully and normally awake	