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

Form B7L: Mayo Sleep Questionnaire — Co-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 co-participant's response. For additional clarification and examples, see LBD Module Coding Guidebook for Follow-up Visit Packet, Form B7L. Check only one box

1. **Do you live with the participant?**	☐ 0 No **(END FORM HERE)** ☐ 1 Yes **(CONTINUE TO QUESTION 2)**
2. **Do you sleep in the same room as the participant?**	☐ 0 No **(CONTINUE TO QUESTION 2a)** ☐ 1 Yes **(SKIP TO QUESTION 3)**
2a. **If no, is it because of his/her sleep behaviors (i.e., snores too loud, acts out dreams, etc.)?**	☐ 0 No ☐ 1 Yes

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

3.		**Have you ever seen the participant appear to "act out his/her dreams" while sleeping (punched or flailed arms in the air, shouted, or screamed)?**	☐ 0 No **(SKIP TO QUESTION 4)** ☐ 1 Yes **(COMPLETE QUESTIONS 3a – 3e)**
	3a.	**How many months or years has this been going on?**	_ _ year(s) _ _ month(s)
	3b.	**Has the participant ever been injured from these behaviors (bruises, cuts, broken bones)?**	☐ 0 No ☐ 1 Yes
	3c.	**Has a bedpartner ever been injured from these behaviors (bruises, blows, pulled hair)?**	☐ 0 No ☐ 1 Yes ☐ 8 No bedpartner

	3d.	**Has the participant told you about dreams of being chased or attacked, or that involve defending himself/herself?**	☐ 0 No ☐ 1 Yes ☐ 8 Never told me about dreams
	3e.	**If the participant woke up and told you about a dream, did the details of the dream match the movements made while sleeping?**	☐ 0 No ☐ 1 Yes ☐ 8 Never told me about dreams
4.		**Do the participant's legs repeatedly jerk or twitch during sleep (not just when falling asleep)?**	☐ 0 No ☐ 1 Yes
5.		**Does the participant complain of a restless, nervous, tingly, or creepy-crawly feeling in his/her legs that disrupts his/her ability to fall or stay asleep?**	☐ 0 No **(SKIP TO QUESTION 6)** ☐ 1 Yes **(COMPLETE QUESTIONS 5a – 5b)**
	5a.	**Does the participant tell you that these leg sensations decrease when he/she moves them or walks around?**	☐ 0 No ☐ 1 Yes
	5b.	**When do these sensations seem to be the worst?**	☐ 1 Before 6:00 p.m. ☐ 2 After 6:00 p.m.
6.		**Has the participant ever walked around the bedroom or house while asleep?**	☐ 0 No ☐ 1 Yes
7.		**Has the participant ever snorted or choked him/herself awake?**	☐ 0 No ☐ 1 Yes
8.		**Does the participant ever seem to stop breathing during sleep?**	☐ 0 No **(SKIP TO QUESTION 9)** ☐ 1 Yes **(COMPLETE QUESTION 8a)**
	8a.	**Is the participant currently being treated for this (e.g., CPAP)?**	☐ 0 No ☐ 1 Yes
9.		**Does the participant have leg cramps at night (e.g., also called a "charlie horse" with intense pain in certain muscles in the leg)?**	☐ 0 No ☐ 1 Yes
10.		**Rate the participant's 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	