

INITIAL VISIT PACKET NACC UNIFORM DATA SET (UDS) **LBD MODULE**

Form B1L: Clinical Symptoms and Exam

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. For additional clarification and examples, see LBD Module Coding Guidebook for Initial Visit Packet, Form B1L. Check only one box per question.

AUTONOMIC SYMPTOMS CHECKLIST

In the past six months ...	No	Yes	Unknown
1. Does the participant dribble saliva during the day?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 9
2. Does the participant have difficulty swallowing?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 9
3. Does the participant have altered interest in sex?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 9
4. Does the participant have problems having sex?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 9
5. Does the participant have a recent change in weight (not related to dieting)?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 9
6. Does the participant report a change in the ability to taste or smell?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 9
7. Does the participant experience excessive sweating (not related to hot weather)?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 9
8. Does the participant report having difficulty tolerating cold weather?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 9
9. Does the participant report having difficulty tolerating hot weather?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 9
10. Does the participant experience double vision (two separate real objects, and not blurred vision)?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 9
11. Does the participant have problems with constipation?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 9
12. Does the participant have to strain to pass hard stools?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 9
13. Has the participant had involuntary loss of stools?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 9
14. Has the participant had the feeling that after passing urine, their bladder was not completely empty?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 9
15. Has the participant's stream of urine been weak or reduced?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 9
16. Has the participant had to pass urine within two hours of the previous urination?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 9
17. Has the participant complained of feeling light-headed or dizzy when standing up?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 9
18. Has the participant become light-headed after standing for some time?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 9
19. Has the participant fainted?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 9

20. Indicate the first predominant symptom to appear during the participant's lifetime: (SELECT ONLY ONE)

- 1 Dribbling saliva during the day
- 2 Difficulty swallowing
- 3 Altered interest in sex
- 4 Problems having sex
- 5 Recent change in weight not related to dieting
- 6 Change in the ability to taste or smell
- 7 Excessive sweating
- 8 Difficulty tolerating cold weather
- 9 Difficulty tolerating hot weather
- 10 Double vision
- 11 Constipation
- 12 Straining to pass hard stools
- 13 Involuntary loss of stools
- 14 Feeling after passing urine that bladder is not completely empty
- 15 Stream of urine weak or reduced
- 16 Passing urine within two hours of previous urination
- 17 Feeling light-headed or dizzy when standing up
- 18 Feeling light-headed after standing for some time
- 19 Fainting
- 88 Not applicable — never experienced any of these symptoms
- 99 Unknown

21. At what age did the first predominant symptom appear? ____ ____ ____ (888=Not applicable; 999=Unknown)

MEASUREMENTS

Supine position	22. Systolic blood pressure:	____ ____ ____ (888=Not assessed)
	23. Diastolic blood pressure:	____ ____ ____ (888=Not assessed)
	24. Heart rate:	____ ____ ____ (888=Not assessed)
Standing position	25. Systolic blood pressure:	____ ____ ____ (888=Not assessed)
	26. Diastolic blood pressure:	____ ____ ____ (888=Not assessed)
	27. Heart rate:	____ ____ ____ (888=Not assessed)

AGE OF ONSET OF NON-MOTOR SYMPTOMS

28. Age of onset of probable REM sleep behavior disorder:	____ ____ ____ (888=Not applicable; 999=Unknown)
29. Age of onset of impaired smell:	____ ____ ____ (888=Not applicable; 999=Unknown)

AGE OF ONSET OF MOTOR SYMPTOMS	
30. Age of onset of gait disorder:	___ ___ ___ (888=Not applicable; 999=Unknown)
31. Age of onset of falls:	___ ___ ___ (888=Not applicable; 999=Unknown)
32. Age of onset of tremor:	___ ___ ___ (888=Not applicable; 999=Unknown)
33. Age of onset of bradykinesia:	___ ___ ___ (888=Not applicable; 999=Unknown)

34. WAS A STANDARDIZED SCALE OF AUTONOMIC SYMPTOMS COMPLETED AT THIS VISIT?
<input type="checkbox"/> 0 No (END FORM HERE) <input type="checkbox"/> 1 Yes (CONTINUE TO QUESTIONS 34a and 34b)
34a. If yes, which version? <input type="checkbox"/> 1 NMSS <input type="checkbox"/> 2 SCOPA-AUT <input type="checkbox"/> 8 Other (SPECIFY): _____
34b. If yes, what was the score? _____ (999 = Unknown)