

INITIAL 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 Initial Visit Packet, Form B6L. Check only one box per question.

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 at least 3 times.

<p>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)?</p>	<p><input type="checkbox"/> 0 No (SKIP TO QUESTION 2)</p> <p><input type="checkbox"/> 1 Yes (COMPLETE QUESTIONS 1a – 1e)</p>
<p>1a. How many months or years has this been going on?</p>	<p>___ ___ year(s)</p> <p>___ ___ month(s)</p>
<p>1b. Have you ever been injured from these behaviors (bruises, cuts, broken bones)?</p>	<p><input type="checkbox"/> 0 No</p> <p><input type="checkbox"/> 1 Yes</p>
<p>1c. Has a bedpartner ever been injured from these behaviors (bruises, blows, pulled hair)?</p>	<p><input type="checkbox"/> 0 No</p> <p><input type="checkbox"/> 1 Yes</p> <p><input type="checkbox"/> 8 No bedpartner</p>
<p>1d. Have you had dreams of being chased or attacked, or that involve defending yourself?</p>	<p><input type="checkbox"/> 0 No</p> <p><input type="checkbox"/> 1 Yes</p>
<p>1e. Have you been told that you make movements while sleeping that seem to match the details of your dream?</p>	<p><input type="checkbox"/> 0 No</p> <p><input type="checkbox"/> 1 Yes</p>

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