

**INITIAL 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 Initial Visit Packet, Form B7L. Check only one box per question.*

1. Do you live with the participant?	<input type="checkbox"/> 0 No (END FORM HERE) <input type="checkbox"/> 1 Yes (CONTINUE TO QUESTION 2)
2. Do you sleep in the same room as the participant?	<input type="checkbox"/> 0 No (CONTINUE TO QUESTION 2a) <input type="checkbox"/> 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.)?	<input type="checkbox"/> 0 No <input type="checkbox"/> 1 Yes

Please mark "Yes" if the described event has occurred at least 3 times.

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)?	<input type="checkbox"/> 0 No (SKIP TO QUESTION 4) <input type="checkbox"/> 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)?	<input type="checkbox"/> 0 No <input type="checkbox"/> 1 Yes
3c.	Has a bedpartner ever been injured from these behaviors (bruises, blows, pulled hair)?	<input type="checkbox"/> 0 No <input type="checkbox"/> 1 Yes <input type="checkbox"/> 8 No bedpartner

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3d.	<b>Has the participant told you about dreams of being chased or attacked, or that involve defending himself/herself?</b>	<input type="checkbox"/> 0 No <input type="checkbox"/> 1 Yes <input type="checkbox"/> 8 Never told me about dreams
3e.	<b>If the participant woke up and told you about a dream, did the details of the dream match the movements made while sleeping?</b>	<input type="checkbox"/> 0 No <input type="checkbox"/> 1 Yes <input type="checkbox"/> 8 Never told me about dreams
4.	<b>Do the participant's legs repeatedly jerk or twitch <u>during</u> sleep (not just when falling asleep)?</b>	<input type="checkbox"/> 0 No <input type="checkbox"/> 1 Yes
5.	<b>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?</b>	<input type="checkbox"/> 0 No (SKIP TO QUESTION 6) <input type="checkbox"/> 1 Yes (COMPLETE QUESTIONS 5a – 5b)
5a.	<b>Does the participant tell you that these leg sensations decrease when he/she moves them or walks around?</b>	<input type="checkbox"/> 0 No <input type="checkbox"/> 1 Yes
5b.	<b>When do these sensations seem to be the worst?</b>	<input type="checkbox"/> 1 Before 6:00 p.m. <input type="checkbox"/> 2 After 6:00 p.m.
6.	<b>Has the participant ever walked around the bedroom or house while asleep?</b>	<input type="checkbox"/> 0 No <input type="checkbox"/> 1 Yes
7.	<b>Has the participant ever snorted or choked him/herself awake?</b>	<input type="checkbox"/> 0 No <input type="checkbox"/> 1 Yes
8.	<b>Does the participant ever seem to stop breathing during sleep?</b>	<input type="checkbox"/> 0 No (SKIP TO QUESTION 9) <input type="checkbox"/> 1 Yes (COMPLETE QUESTION 8a)
8a.	<b>Is the participant currently being treated for this (e.g., CPAP)?</b>	<input type="checkbox"/> 0 No <input type="checkbox"/> 1 Yes
9.	<b>Does the participant have leg cramps at night (e.g., also called a “charlie horse” with intense pain in certain muscles in the leg)?</b>	<input type="checkbox"/> 0 No <input type="checkbox"/> 1 Yes
10.	<b>Rate the participant's general level of alertness for the past 3 weeks on a scale from 0 to 10: ____</b>  0 — 1 — 2 — 3 — 4 — 5 — 6 — 7 — 8 — 9 — 10 Sleep all day <span style="float: right;">Fully and normally awake</span>	