National Alzheimer's Coordinating Center

FOLLOW-UP VISIT PACKET NACC UNIFORM DATA SET (UDS) **LBD MODULE V3.1 SHORT VERSION**

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 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.

Question	Response
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 behaviors (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

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2. **Have you been told that your legs repeatedly jerk or twitch <u>during</u> 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