NACC
National Alzheimer's Coordinating Center

INITIAL 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 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.

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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Question	Response
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 (0) … Fully and normally awake (10)