NACC
National Alzheimer's Coordinating Center

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

# **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.*

| Question | Response |
|---|---|
| 1. **Do you live with the participant?** | ☐ 0 No **(END FORM HERE)**<br>☐ 1 Yes **(CONTINUE TO QUESTION 2)** |
| 2. **Do you sleep in the same room as the participant?** | ☐ 0 No **(CONTINUE TO QUESTION 2a)**<br>☐ 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.)?** | ☐ 0 No<br>☐ 1 Yes |

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

| | | Question | Response |
|---|---|---|---|
| 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)?** | ☐ 0 No **(SKIP TO QUESTION 4)**<br>☐ 1 Yes **(COMPLETE QUESTIONS 3a – 3e)** |
| | 3a. | **How many months or years has this been going on?** | ___ ___ year(s)<br>___ ___ month(s) |
| | 3b. | **Has the participant ever been injured from these behaviors (bruises, cuts, broken bones)?** | ☐ 0 No<br>☐ 1 Yes |
| | 3c. | **Has a bedpartner ever been injured from these behaviors (bruises, blows, pulled hair)?** | ☐ 0 No<br>☐ 1 Yes<br>☐ 8 No bedpartner |

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