Mayo Sleep Questionnaire—Informant

Do you live with the patient?  □ Yes  □ No  (If No, END FORM HERE)

Do you sleep in the same room as the patient? □ Yes □ No

If no, is it because of his/her sleep behaviors (i.e. snores too loud, acts out dreams, etc.)? □ Yes □ No

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

1. Have you ever seen the patient appear to “act out his/her dreams” while sleeping? (punched or flailed arms in the air, shouted or screamed)

□ 0 no
□ 1 yes

- If Yes,
  a. How many months or years has this been going on?

□ year(s)
□ months

b. Has the patient ever been injured from these behaviors (bruises, cuts, broken bones)?

□ No
□ Yes

c. Has a bedpartner ever been injured from these behaviors (bruises, blows, pulled hair)?

□ No
□ Yes
□ No bedpartner

d. Has the patient told you about dreams of being chased, attacked or that involve defending himself/herself?

□ No
□ Yes
□ Never told you about dreams
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<td>e. If the patient woke up and told you about a dream, did the details of the dream match the movements made while sleeping?</td>
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<tr>
<td></td>
<td>No</td>
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<td>Never told you about dreams</td>
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2. Do the patient’s legs repeatedly jerk or twitch **during** sleep (not just when falling asleep)?

|   | No | Yes |

3. Does the patient complain of a restless, nervous, tingly, or creepy-crawly feeling in his/her legs that disrupts his/her ability to fall or stay asleep?

|   | No | Yes |

- **If Yes,**

a. Does the patient tell you that these leg sensations decrease when he/she moves them or walks around?

|   | No | Yes |

b. When do these sensations seem to be the worst?

|   | before 6 pm | after 6 pm |

4. Has the patient ever walked around the bedroom or house while asleep?

|   | No | Yes |
5. Has the patient ever snorted or choked him/herself awake?
   - [ ] No
   - [ ] Yes

6. Does the patient ever seem to stop breathing during sleep?
   - [ ] No
   - [ ] Yes

   • **If Yes,**
     a. Is the patient currently being treated for this (e.g., CPAP)?
        - [ ] No
        - [ ] Yes

7. Does the patient have leg cramps at night? (e.g., also called a “charlie horse” with intense pain in certain muscles in the leg)?
   - [ ] No
   - [ ] Yes

8. Rate the patient’s 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 Fully &
   all day normally
   awake