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 <u>at least 3 times.</u>

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

   - **<u>If Yes</u>,**

     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**

e. If the patient woke up and told you about a dream, did the details of the dream match the movements made while sleeping?

☐ **No**
☐ **Yes**
☐ **Never told you about dreams**

2. Do the patient's legs repeatedly jerk or twitch <u>during</u> 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**

- **<u>If Yes</u>,**

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**

- **<u>If Yes</u>,**

  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 all day										**Fully & normally awake**