Screening Questionnaire:

Restless Legs Syndrome

(Bedpartner Version)

Partner’s Name: _________________________________________

Person filling out form: __________________________________

1. Does your partner have “leg pains”? (Check One)
   ______ never ______ occasionally ______ sometimes _______ frequently
   (less than 1x/month)      (1-2x/month)      (1-2x/wk to daily)

2. Does your partner complain of uncomfortable or funny feelings (creeping,
crawling, tingling) in his/her legs? (Check One)
   ______ never ______ occasionally ______ sometimes _______ frequently
   (less than 1x/month)      (1-2x/month)      (1-2x/wk to daily)

3. Does your partner:
   
   A. Notice funny feelings in his/her legs
      (or do they seem worse) when lying down
      or sitting?
      ______     _____     _____

   B. Have partial relief with movement
      (wiggling feet, toes, or walking?)
      ______     _____     _____

   C. Complain that the feelings are worse
      at night?
      ______     _____     _____

   D. Have a lot of fidgeting or wiggling of the
      feet or toes when sitting or lying down?
      ______     _____     _____

   E. Have repeated jerking movements in
      toes or legs or the whole body while
      sleeping?
      ______     _____     _____
4. Does your partner appear restless while sleeping (thrashing around, banging feet against wall, twisting covers, or falling out of bed)? (Check One)

_______ never ______ occasionally ______ sometimes ______ frequently
(less than 1x/month) (1-2x/month) (1-2x/wk to daily)

5. Has anyone in the family (including grandparents, aunts/uncles) been diagnosed with restless legs or periodic leg movements during sleep?

_____Yes _______No

If so, who: __________________________

6. Does anyone in the family have severe problems falling or staying asleep?

_____Yes_______No

If so, who:___________________.

Type of problem, if known: _______________________________

7. How often, on average, does your partner consume caffeine-containing beverages or food? (coffee, tea, cola beverages, chocolate)

______ never ______ occasionally _____ sometimes ______ frequently
(less than 1x/month) (1-2x/month) (1-2x/wk to daily)

8. Has your partner ever been diagnosed and/or treated for anemia?

Yes___ No___ Don’t Know___

Date, type of anemia, and treatment, if known: ________________________________
Screening Questionnaire:
Restless Legs Syndrome
(Patient Self-Report Version)

Your name:__________________________________________

1. Have you ever had “growing pains”? (Check one)
___ never ___ occasionally ___ sometimes ___ frequently ___ only in the past
   (less than 1x/month)   (1-2x/month)  (1-2x/wk to daily)

2. Do you have uncomfortable or funny feelings (creeping, crawling, tingling) in
your legs? (Check one)
___ never ___ occasionally ___ sometimes ___ frequently ___ only in the past
   (less than 1x/month)   (1-2x/month)  (1-2x/wk to daily)

3. Do you ever:

   A. Notice funny feelings in your legs (or do they seem worse) when lying
down or sitting? YES   NO   DON’T KNOW
      ____   ____   ____

   B. Have partial relief with movement (wiggling feet, toes, or walking?)
      ____   ____   ____

   C. Notice that the feeling is worse at night?
      ____   ____   ____

   D. Have a lot of fidgeting or wiggling of your feet or toes when sitting or
      lying down?
      ____   ____   ____

   E. Have repeated jerking movements in toes or legs or the whole body while sleeping?
      ____   ____   ____