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:

   YES    NO    DON’T KNOW

   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?
      ____  ____  ____