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)

	YES	NO	DON'T KNOW
3. Does your partner:			
A. Notice funning 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?	_____	_____	_____

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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) (1-2xmonth) (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:

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

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