

Bed Partner Questionnaire

(To be completed by pt's bed partner)

Patient Name: _____ Date: _____

Your Name: _____ Relationship: _____

I have observed this person sleep (circle one): Never Once Twice Often Every Night

Check any of the following that you have observed this person doing while asleep. **Check** those that you consider severe problems.

- | | |
|---|--|
| <input type="checkbox"/> Light Snorer | <input type="checkbox"/> Becoming very rigid and shaking |
| <input type="checkbox"/> Moderate Snorer | <input type="checkbox"/> Apparently sleeping even if he/she says otherwise |
| <input type="checkbox"/> Loud Snorer | <input type="checkbox"/> Occasional Loud Snorts |
| <input type="checkbox"/> Twitching or Kicking of Legs | <input type="checkbox"/> Grinding Teeth |
| <input type="checkbox"/> Choking | <input type="checkbox"/> Pauses in Breathing |
| <input type="checkbox"/> Sitting up in bed Not Awake | <input type="checkbox"/> Sleep Talking |
| <input type="checkbox"/> Head Rocking or Banging | <input type="checkbox"/> Bed-wetting |
| <input type="checkbox"/> Biting Tongue | <input type="checkbox"/> Awakening with Pain |
| <input type="checkbox"/> Crying out | <input type="checkbox"/> Getting out of bed Not Awake |

Other _____

If this person snores, what makes it worse?

- | | |
|---|----------------------------------|
| <input type="checkbox"/> Sleeping on his/her back | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Sleeping on his/her side | <input type="checkbox"/> Alcohol |

Please describe the behaviors checked in more detail. Describe the time when it occurs, how often it occurs during the night, and whether it occurs every night.

Has this person fallen asleep during normal daytime activities or in dangerous situations? Yes/No? If yes, please explain: _____

Does this person use sleeping pills? Yes/No? What kind? _____
How often? _____

Does this person drink alcohol? Yes/No?

Please estimate the per (weeknight/weekend) use of: ___/___ 12 oz. Bottle/can/tap beer. ___/___ 6-8 oz. Glasses of wine ___/___ 1-1/2 oz. bottle/cap/tap liquor.

Please estimate how much alcohol this person consumes in the 3 hours before bed:

If this person uses recreational drugs, please describe both the types and frequency of usage:
