



BED PARTNER QUESTIONNAIRE

Patient: _____ Observer: _____

Relationship of Observer to Patient: _____ Date: _____

Frequency of observations: Once or twice Often Almost every night

Check any of the following behaviors observed while watching person sleep. Circle behaviors that you consider severe problems for this person.

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|---|---|
| <input type="checkbox"/> Light snoring | <input type="checkbox"/> Sleep talking |
| <input type="checkbox"/> Loud snoring | <input type="checkbox"/> Sitting up in bed not awake |
| <input type="checkbox"/> Loud snorts | <input type="checkbox"/> Getting out of bed not awake |
| <input type="checkbox"/> Pause in breathing (How long? ____seconds) | <input type="checkbox"/> Head rocking or banging |
| <input type="checkbox"/> Choking | <input type="checkbox"/> Awakening with pain |
| <input type="checkbox"/> Gasping for air | <input type="checkbox"/> Becoming very rigid or shaking |
| <input type="checkbox"/> Twitching, moving or kicking of legs | <input type="checkbox"/> Biting tongue |
| <input type="checkbox"/> Twitching or flinging of arms | <input type="checkbox"/> Crying out |
| <input type="checkbox"/> Grinding teeth | |
| <input type="checkbox"/> Apparently sleeping even if person behaves otherwise | |
| <input type="checkbox"/> Other _____ | |

If person snores, what makes snoring worse?

- Sleeping on back Sleeping on side Alcohol Fatigue

Does snoring sometimes require you or your partner to sleep separately? Yes No

Does this person drink alcohol or use street drugs? Yes No

