Bed Partner Questionnaire

Name of patient: _____

Your relationship to patient: _____

How often have you observed this person's sleep?

☐ Never ☐ Once or twice ☐ Often ☐ Every night

Has this person fallen asleep during normal daytime activities or in dangerous situations? If yes, explain: _____

_____

What behaviors have you observed in this person while he or she was asleep? Check all that apply.

☐ Light snoring	☐ Limb movement every 10-20 seconds	☐ Teeth grinding
☐ Loud snoring	☐ Awakening with pain	☐ Sitting up in bed
☐ Occasional loud snorts	☐ Leg or arm twitching	☐ Head rocking/banging
☐ Choking	☐ Leg kicking	☐ Sleepwalking
☐ Pauses in breathing	☐ Shaking or rocking	☐ Bedwetting
	☐ Becoming very rigid	☐ Doing an unusual activity

☐ Other _____

Please describe the checked behaviors in more detail. Include a description of the behavior, when it occurs during the night, frequency during the night, and how often it occurs (every night, 4 times a week, etc.).

_____

_____

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