

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.

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