

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.).
