BED PARTNER QUESTIONNAIRE - PAGE 1

(PLEASE ASK SOMEONE WHO HAS WATCHED YOU SLEEP TO COMPLETE THIS FORM)

PATIENT NAME:_____ **OBSERVER:**_____ **RELATIONSHIP:**_____ **DATE:**_____

1. I HAVE OBSERVED THIS PERSON'S SLEEP:

☐ Once or Twice ☐ Often ☐ Almost Every Night

2a. CHECK ANY BEHAVIORS YOU HAVE OBSERVED WHILE THIS PERSON SLEEPS.
2b. CIRCLE ANY BEHAVIORS YOU CONSIDER TO BE SEVERE PROBLEMS FOR THIS PERSON.

☐ light snoring ☐ loud snoring
☐ loud snorts ☐ choking
☐ gasping for air ☐ pauses in breathing (how long? _____seconds)
☐ twitching/kicking of legs ☐ twitching/flailing of arms
☐ sleep talking ☐ grinding teeth
☐ bed-wetting ☐ sitting up in bed not awake
☐ awakening with pain ☐ head rocking or banging
☐ bitting tounge ☐ getting out of bed not awake
☐ crying out ☐ becoming very ridgid and/or shaking
☐ seemingly asleep even if behaving otherwise
☐ other: _____

3. IF THIS PERSON SNORES, WHAT MAKES IT WORSE?

☐ Alcohol ☐ Sleeping on their side
☐ Fatigue ☐ Sleeping on their back

4. DOES THE SNORING EVER REQUIRE SLEEPING SEPARATELY?

☐ Yes ☐ No

5. DOES THIS PERSON DRINK ALCOHOL?

☐ Yes ☐ No

6. IF YES, CHECK ALL THAT APPLY:

☐ Beer ☐ Wine ☐ Liquor

7. PLEASE ESTIMATE THE PER WEEK USE OF ALCOHOL BY THIS PERSON:

_____ 12 oz. beer
_____ 6 - 8 oz. wine
_____ 1 - ½ oz. Liquor

8. PLEASE ESTIMATE HOW MUCH ALCOHOL THIS PERSON DRINKS IN THE 3 HOURS BEFORE BED:_____

9. DO YOU CONSIDER THIS PERSON'S DRINKING A PROBLEM?

☐ Yes ☐ No ☐ Uncertain

10. IF THIS PERSON USES STREET DRUGS, PLEASE DESCRIBE BOTH THE TYPES AND FREQUENCY OF USAGE:

_____
_____
_____

11. DO YOU BELIEVE THAT THIS PERSON AND YOURSELF SHARE THE SAME UNDERSTANDING ABOUT THEIR SLEEP PROBLEM, SLEEPING PILL USAGE AND ALCOHOL/DRUG USAGE?

☐ Yes ☐ No

COMMENTS:_____
_____
_____