

BED PARTNER QUESTIONNAIRE

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

Patient's Name _____ Date: _____

Observer's Name: _____ Relationship to Patient: _____

I have observed this person's sleep:

- Once or Twice Often Almost Every Night

Please mark the severity of the following behaviors that you have observed this person doing **while asleep**

	MILD	MODERATE	SEVERE		MILD	MODERATE	SEVERE
Loud snoring	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Choking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loud snorts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gasping for air	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pause in breathing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Twitching/flinging of arms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Twitching or kicking of legs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Grinding teeth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep talking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sitting up in bed not awake	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bed-wetting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Head rocking/banging	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Awakening with pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Biting tongue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Getting out of bed not awake	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Crying out	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Becoming very rigid/shaking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Apparently sleeping even if	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				

he/she behaves otherwise

If this person snores, what makes it worse?

- sleeping on his/her back sleeping on his/her side alcohol fatigue

How often does the snoring require you and your partner to sleep separately? Rarely Sometimes Often

Modified Epworth Sleepiness Scale

As an observer, please complete the following information on your estimation of the chances of his/her dozing in the following situations. (Even if none of these things have occurred recently, try to work out how they would have affected him/her.) Use the scale below to choose the most appropriate number for each situation.		
Scale	Situation	Chance of Dozing
0 – would never doze 1 – slight chance of dozing 2 – moderate chance of dozing 3 – high chance of dozing	Sitting & Reading	_____
	Watching TV	_____
	Sitting inactive in a public place (i.e., theater)	_____
	As a car passenger for an hour without a break	_____
	Lying down to rest in the afternoon	_____
	Sitting & talking to someone	_____
	Sitting quietly after lunch without alcohol	_____
	In a car, while stopping for a few minutes in traffic	_____
	Total Score	_____

SLEEP OBSERVER QUESTIONNAIRE – (Continued)

Does this person drink alcohol? Yes No

If yes, this person usually drinks: (check as many as you believe appropriate)

beer wine shots of liquor

Please estimate the **per week** use of:

_____ 12 oz. bottle/can/tap **BEER**

_____ 6-8 oz. glasses of **WINE**

_____ 1-1½ oz. **LIQUOR**

Do you consider this person's drinking a problem? Yes No Uncertain

Comments: _____

If this person uses street drugs, please describe both the types and frequency of usage:

Do you believe this person and yourself share the same understanding about his/her sleep problem, sleeping pill usage, and alcohol/drug usage? Yes No

Comments:
