Bed Partner (or Observer) Questionnaire

Date:_____ Patient's Name:_____

Your name and relation to patient: _____

How long have you known patient? _____

How long have you observed the patient's sleep? _____

Does this patient's sleep bother you? Yes No Why? _____

Why do you feel the patient's sleep needs to be evaluated? _____
_____

_____

Have you observed the patient having any of the following:

Snoring	Yes	No	Sleep Walking	Yes	No
Stop breathing	Yes	No	Bed Wetting	Yes	No
Gasping or Choking	Yes	No	Teeth Grinding	Yes	No
Leg or body jerks	Yes	No	Difficulty falling asleep	Yes	No
Violent or strange behavior	Yes	No	Difficulty staying asleep	Yes	No
Acting out dreams	Yes	No	Difficulty arising	Yes	No
Falling asleep driving	Yes	No	Driving off on berm	Yes	No
Appearing too sleepy	Yes	No	Fall asleep when shouldn't	Yes	No

How long have the above issues been going on? Less than 1 year 1 to 5 years More than 5 years

Rate the patient's sleep quality on a scale of 1 to 10: 1 2 3 4 5 6 7 8 9 10
Horrible Fair Excellent