Bed Partner Questionnaire

To be completed by the Patient's bed partner, without influence of the Patient. Please complete and have the Patient bring with them to their sleep study appointment.

Patient's Name: _____ Date: _____
Relationship to Patient: _____

Please estimate how many hours of sleep your bed partner gets:

Sleep Schedule:	**Hours Each Night:**	**How Long does it take to fall asleep?**	**How long is your partner awake during the night?**
Work Days:			
Days Off:			

Mark any positions your bed partner sleeps in: ☐ Back ☐ Side ☐ Stomach

Does your bed partner snore? ☐ Never ☐ Occasionally ☐ Often ☐ Unknown
If they snore, please mark the positions they snore in: ☐ Back ☐ Side ☐ Stomach

How loud is his/her snoring? ☐ 1 (Light) ☐ 2 ☐ 3 ☐ 4 ☐ 5 (Loud)

Does your bed partner do any of the following in his/her sleep? (Please mark all that apply)
☐ Gagging ☐ Choking ☐ Snorting ☐ Gasping ☐ Teeth Grinding ☐ Kicking their feet

	Never	Occasionally	Often	Unknown
Does you bed partner take naps during the day?				
Does your partner stop breathing in his/her sleep?				
Does your bed partner fall asleep when driving?				
Does he/she fall asleep without warning?				
Does your bed partner kick their legs while sleeping?				
Does your bed partner mumble, talk, or yell during sleep?				

Does your bed partner awaken during the night? ☐ Never ☐ Occasionally ☐ Often ☐ Unknown
If they awaken, how long does it take them to get back to sleep? Hrs: ____ Mins: _____ ☐ Unknown
Do you know why he/she awakens? ☐ Yes ☐ No If yes, Why? _____
_____

Is you bed partner restless during sleep? ☐ Never ☐ Occasionally ☐ Often ☐ Unknown
Describe what they do when restless: _____
_____
_____

How much stress does your bed partner currently have? ☐ 1 (Light) ☐ 2 ☐ 3(A Lot) ☐ Unknown

Please estimate your bed partner's risk of falling asleep or dozing off in the following situations, using the following scale: 0 = No chance 1= Slight chance 2= Moderate chance 3= High chance

Sitting and reading : ☐ 0 ☐ 1 ☐ 2 ☐ 3	Lying down to rest in the afternoon : ☐ 0 ☐ 1 ☐ 2 ☐ 3
Watching TV : ☐ 0 ☐ 1 ☐ 2 ☐ 3	As a passenger in a car, for an hour, with no break : ☐ 0 ☐ 1 ☐ 2 ☐ 3
Sitting, inactive, in public (Theater, Meetings, Etc,) : ☐ 0 ☐ 1 ☐ 2 ☐ 3	Sitting quietly after lunch, without Alcohol: ☐ 0 ☐ 1 ☐ 2 ☐ 3
Sitting and talking to someone: ☐ 0 ☐ 1 ☐ 2 ☐ 3	In a car, stopped in traffic, for a few minutes: ☐ 0 ☐ 1 ☐ 2 ☐ 3

Has your bed partner's mood, memory, concentration, or personality deteriorated or changed?
☐ Yes ☐ No If yes, please explain: _____

Does your bed partner's sleep problems disrupt your sleep? ☐ Never ☐ Occasionally ☐ Often
Explain: _____

Please use this space for any other information you would like to add.

Thank you for completing this form.