Bed – Partner Questionnaire

Name of Patient: _____ Date: _____ Time: _____

Name of person filling out this form: _____

I have observed this person's sleep: _____Never _____Every Night _____Once or Twice _____Often

Check any of the following behaviors that you have observed this person doing **while asleep**.

_____ Light snoring
_____ Loud snoring
_____ Occasional loud snorts
_____ Choking
_____ Pauses in breathing
_____ Twitching or kicking of legs during sleep
_____ Grinding teeth
_____ Sleepwalking
_____ Bed wetting
_____ Biting tongue
_____ Twitching or jerking of arms during sleep
_____ Crying out
_____ Sitting up in bed but not awake
_____ Awakening with pain
_____ Getting out of bed but not awake
_____ Becoming very rigid And/or shaking
_____ Head rocking or banging
_____ Apparently sleeping even if he/she behaves otherwise
_____ Other: Explain: _____
_____ None of the Above

Please describe the sleep behaviors checked in more detail. Include a description of the activity, the time during the night when it occurs, frequency during the night, and whether it occurs every night.

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Has this person ever fallen asleep during normal daytime activities or in dangerous situations? _____

If yes, please explain: _____

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