

# 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:

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

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 your 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 your bed partner restless during sleep?     Never     Occasionally     Often     Unknown

Describe what they do when restless: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

