

Alaska Sleep Clinic

Bed Partner Questionnaire

Patient Name: _____ Date: _____

Your Name: _____ Relationship: _____

I have observed this person's sleep (circle one): Never Once or twice Often Every night

Check any of the following behaviors that you have observed this person doing while asleep. *Circle* those that you consider severe problems.

- | | |
|---|--|
| <input type="checkbox"/> Light snorer | <input type="checkbox"/> Becoming very rigid and shaking |
| <input type="checkbox"/> Moderate snorer | <input type="checkbox"/> Apparently sleeping even if he/she says otherwise |
| <input type="checkbox"/> Loud snorer | <input type="checkbox"/> Twitching or kicking of legs |
| <input type="checkbox"/> Occasional loud snorts | <input type="checkbox"/> Grinding teeth |
| <input type="checkbox"/> Choking | <input type="checkbox"/> Sitting up in bed not awake |
| <input type="checkbox"/> Pauses in breathing | <input type="checkbox"/> Head rocking or banging |
| <input type="checkbox"/> Sleep talking | <input type="checkbox"/> Biting tongue |
| <input type="checkbox"/> Bed-wetting | <input type="checkbox"/> Crying out |
| <input type="checkbox"/> Awakening with pain | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Getting out of bed not awake | |

If this person snores, what makes it worse?

- | | |
|---|----------------------------------|
| <input type="checkbox"/> Sleeping on his/her back | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Sleeping on his/her side | <input type="checkbox"/> Alcohol |

Please describe the behaviors checked in more detail. Describe the time when it occurs, how often it occurs during the night, and whether it occurs every night.

Has this person fallen asleep during normal daytime activities or in dangerous situations? Yes / No

If yes, please explain: _____

Does this person use sleeping pills? Yes / No What kind? _____ How often? _____

Does this person drink alcohol? Yes / No Please estimate the per (week night/weekend night) use of:

___/___ 12 oz. Bottle/can/tap beer ___/___ 6-8 oz. Glasses of wine ___/___ 1-1/2 oz bottle/cap/tap liquor

Please estimate how much alcohol this person consumes in the 3 hours before bed: _____

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