BED PARTNER SURVEY

GIVE TO BED PARTNER

To help us with a proper diagnosis and appropriate treatment plan, have your bed partner, if applicable and available, fill out this questionnaire regarding YOUR sleep habits. This information is vitally important for Dr. Sullivan to best evaluate your current condition.

TO BE FILLED OUT BY THE PATIENT'S BED PARTNER

Patient's Name _____

1. YES NO Do you witness the patient snoring?_____
2. YES NO Do you witness the patient choking or gasping for breath during sleep?
3. YES NO Does the patient pause or stop breathing during sleep?_____
4. YES NO Does the patient fall asleep easily, if given the opportunity, during the day (normal wakeful hours)?_____
5. YES NO Do you witness the patient clenching and/or grinding his/her teeth during sleep?
6. YES NO Does the patient appear refreshed upon waking?_____
7. YES NO Do the patient's sleep habits disturb your sleep?_____
8. YES NO Does the patient sit up in bed, not awake?_____
9. Please check those sleep habits of the patient that are disturbing to you:

- ☐ Snores
- ☐ Restless
- ☐ Other_____
- ☐ Wakes up often
- ☐ Loud gasping for breath while sleeping
- ☐ Stops breathing
- ☐ Grinds teeth
- ☐ Becoming very rigid or shaking
- ☐ Biting tongue
- ☐ Kicking during sleep
- ☐ Head rocking or banging
- ☐ Bed-wetting
- ☐ Sleepwalking
- ☐ Sleep talking

Comments:_____

OVER

BED PARTNER SURVEY

GIVE TO BED PARTNER

How likely is your partner to doze off or fall asleep in the following situations, in contrast to just feeling tired?

This refers to daily life in recent times, if these things have not occurred recently, try to work out how they would have affectedyour partner.

Use the following scale and choose the most appropriate number for each situation:

Sitting and reading _____
Watching TV _____
Sitting inactive in a public place (e.g. A theater or a meeting) _____
As a passenger in a car for an hour without a break _____
Lying down to rest in the afternoon when circumstances permit _____
Sitting and talking to someone _____
Sitting quietly after a lunch without alcohol _____
In a car, while stopped for a few minutes in traffic _____

0 Would never doze
1 Slight chance of dozin
2 = Moderate chance of dozing
3= High chance of dozing

Additional comments regarding the patient's sleep habits not mentioned above:

_____

_____

_____

_____

Please sign and date at the bottom ofthis form and many thanks foryour help.

Partner's Signature_____ Date_____