

# **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 affected your partner.*

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

- |   |   |                           |
|---|---|---------------------------|
| Sitting and reading _____   | 0 | Would never doze          |
| Watching TV _____   |   |                           |
| Sitting inactive in a public place<br>(e.g. A theater or a meeting) _____ | 1 | Slight chance of dozing   |
| As a passenger in a car for an hour without a break _____                 | 2 | Moderate chance of dozing |
| Lying down to rest in the afternoon when<br>circumstances permit _____    | 3 | High chance of dozing     |
| Sitting and talking to someone _____                                      |   |                           |
| Sitting quietly after a lunch without alcohol _____                       |   |                           |
| In a car, while stopped for a few minutes in traffic _____                |   |                           |

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

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*Please sign and date at the bottom of this form and many thanks for your help.*

Partner's Signature \_\_\_\_\_ Date \_\_\_\_\_