SLEEP WELL MEDICAL CLINIC, ***A CENTER FOR SLEEP DISORDERS***

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BED PARTNER QUESTIONNAIRE

Name of Patient: _____

Name of person filling out this form: _____

I have observed this person's sleep:	☐ Never	☐ Once or Twice	☐ Often	☐ Every Night

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/kicking of the legs
☐ Bed wetting	☐ Biting tongue	☐ Twitching/jerking of the arms
☐ Crying out	☐ Head rocking/ banging	☐ Sitting up in bed not awake
☐ Awakening with pain	☐ Getting out of bed	☐ Becoming rigid and/or shaking

☐ Other:_____

Please describe the other 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?

☐ Yes ☐ No if yes, please explain:

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