



**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**:

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Light snoring       | <input type="checkbox"/> Loud Snoring          | <input type="checkbox"/> Occasional loud snorts        |
| <input type="checkbox"/> Choking             | <input type="checkbox"/> Pauses in breathing   | <input type="checkbox"/> Twitching/kicking of the legs |
| <input type="checkbox"/> Bed wetting         | <input type="checkbox"/> Biting tongue         | <input type="checkbox"/> Twitching/jerking of the arms |
| <input type="checkbox"/> Crying out          | <input type="checkbox"/> Head rocking/ banging | <input type="checkbox"/> Sitting up in bed not awake   |
| <input type="checkbox"/> Awakening with pain | <input type="checkbox"/> Getting out of bed    | <input type="checkbox"/> Becoming rigid and/or shaking |
| <input type="checkbox"/> 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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