SIOUX FALLS Sleep Center

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Bed Partner Questionnaire

Patient Name: _____ Date: _____

What is your relationship to the patient? _____

Check any of the following behaviors that you have observed the patient doing **while asleep**:

___ twitching of legs or feet
___ Pauses in breathing
___ Grinding teeth
___ Sleep talking
___ Sleepwalking
___ Bedwetting
___ sitting up in bed while still asleep
___ Head rocking or banging
___ kicking with legs
___ getting out of bed while still asleep
___ Biting tongue
___ becoming very rigid and/or shaking
___ loud snoring
___ soft snoring

How long have you been aware of the sleep behavior(s) that you checked above?

_____
_____
_____
_____

Describe the behavior(s) checked above in more detail. Include a description of the activity, the time during the night when it occurs, how many times during the night and whether it occurs every night.

_____
_____
_____
_____

If you have heard loud snoring, describe it in more detail. Include descriptions of any pauses in breathing or occasional loud “snorts” that you may have noticed.

_____
_____
_____
_____