



Bed Partner Questionnaire

To be completed by the Patient's Bed Partner, without influence of the Patient.
 Please complete and have the patient bring with them to their sleep study appointment.

Patient's Name: _____ Date: _____

Relationship to Patient: _____

Please estimate how many hours of sleep your bed partner gets:

Sleep Schedule:	Hours Each Night:	How Long does it take to fall asleep?	How Long is your partner awake during the night?
Work Days:			
Days Off:			

Mark any positions your bed partner sleeps in: Back Side Stomach
 Does your partner snore? Never Occasionally Often Unknown
 If they snore, please mark the positions they snore in: Back Side Stomach
 How loud is her/his snoring? 1 (Light) 2 3 4 5 (Loud)

Does your bed partner do any of the following in his/her sleep? (Please mark all that apply)

Gagging Choking Snoring Gasping Teeth Grinding Kicking their Feet

	Never	Occasionally	Often	Unknown
Does your bed partner take naps during the day?				
Does your bed partner stop breathing in his/her sleep?				
Does your bed partner fall asleep when driving?				
Does he/she fall asleep without warning?				
Does your bed partner kick their legs while sleeping?				
Does your bed partner mumble, talk, or yell during sleep?				

Does your bed partner awaken during the night? Never Occasionally Often Unknown

If the awaken, how long does it take them to get back to sleep? Hrs.: ____ Mins: ____ ____ Unknown

Do you know why he/she awakens? Yes No If yes, why? _____

Does your bed partner's sleep problems disrupt your sleep? Never Occasionally Often

How Much Stress does your bed partner currently have? 1 (Light) 2 3 4 5 (High)

Please use this space for any other information would like to share.