**Bed Partner or Observer Questionnaire**

Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Your name and relationship to patient:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone# ( )\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Work # ( )\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How long have you known the patient? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How long have you observed the patient’s sleep? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Why do you think the patient’s sleep should be evaluated? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Snoring:**

 Does the patient snore? Yes No

 If yes please answer the following:

* Is the snoring loud?
* Is the snoring irregular; pauses or decreases in volume, followed by gasping?
* Does the snoring occur only when the patient is lying on their back?
* Does the snoring occur every night and for the entire night?
* Is the snoring occasional or infrequent?
* Does the snoring increase with alcohol intake or increased fatigue?

**Other Events During Sleep:**

* Does the patient exhibit repeated leg or arm jerks during sleep?
* Does the patient toss or turn restlessly when sleeping?
* Does the patient sweat heavily while asleep?
* Does the patient stop breathing while asleep?
* Does the patient gag or choke while asleep?
* Has the patient ever wet the bed as an adult?
* Has the patient ever turned bluish, grayish or dusky while asleep?
* Does the patient appear to “act out” their dreams?
* Has the patient ever become violent while asleep?
* Have the patient’s eyes ever rolled up while they were sleeping?
* Does the patient ever scream while sleeping?
* Has the patient ever fallen out of bed?
* Does the patient sleepwalk?

If yes, please answer the following:

* While sleepwalking, does the patient seem clammy?
* While sleepwalking, does the patient seem agitated or excited?
* While sleepwalking, has the patient ever left the house?

**Waking Behaviors:**

* Does the patient seem very sleepy when awake?
* Does the patient fall asleep at inappropriate times?
* Does the patient have difficulty with attention, concentration or memory?
* Has the patient ever fallen asleep while driving?
* Has the patient ever had muscular weakness following a strong emotion?
* Has the patient ever suddenly collapsed or fallen?
* Does the patient have episodes of staring or “going blank”?
* Does the patient have episodes of confusion?
* Does the patient experience “panic attacks”?
* Has the patient ever had seizures or convulsions?
* Does the patient seem depressed or irritable?
* Does the patient seem to be aware of his or her own sleepiness?

Please rate the patient’s

**Quality of sleep:**  1 2 3 4 5 6 7

 Poor Average Excellent

**Level of Alertness:** 1 2 3 4 5 6 7

 Poor Average Excellent

Miscellaneous:

Please add any additional observations, comments or concerns you might have about the patient.