EASTERN IOWA
SLEEP CENTER

BED PARTNER QUESTIONNAIRE

F-16

Name of Patient _____ Date: _____

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

- ❒ Loud snoring
- ❒ Light snoring
- ❒ Twitching of legs or feet during sleep
- ❒ Pause in breathing
- ❒ Grinding teeth
- ❒ Sleep talking
- ❒ Sleepwalking
- ❒ Bed wetting
- ❒ Sitting up in bed but not awake
- ❒ Head rocking or banging
- ❒ Kicking with legs during sleep
- ❒ Getting out of bed but not awake
- ❒ Biting tongue
- ❒ Becoming very rigid and/or shaking

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

_____
_____
_____

Describe the behavior checked above 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.

_____
_____
_____

If you have heard loud snoring, do you remember pauses in the snoring or occasional loud "snorts"?

_____
_____
_____

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