BED PARTNER QUESTIONNAIRE

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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________________________________________________________________________
________________________________________________________________________