BED PARTNER SURVEY

GIVE TO BED PARTNER

To help us with a proper diagnosis and appropriate treatment plan, have your bed partner, if applicable and available, fill out this questionnaire regarding YOUR sleep habits. This information is vitally important for Dr. Allman to best evaluate your current condition.

TO BE FILLED OUT BY THE PATIENT'S BED PARTNER

Patient's Name _____

1. YES NO Do you witness the patient snoring?_____
2. YES NO Do you witness the patient choking or gasping for breath during sleep?
3. YES NO Does the patient pause or stop breathing during sleep?_____
4. YES NO Does the patient fall asleep easily, if given the opportunity, during the day (normal wakeful hours)?_____
5. YES NO Do you witness the patient clenching and/or grinding his/her teeth during sleep?
6. YES NO Does the patient appear refreshed upon waking?_____
7. YES NO Do the patient's sleep habits disturb your sleep?_____
8. YES NO Does the patient sit up in bed, not awake?_____
9. Please check those sleep habits of the patient that are disturbing to you:

- ☐ Snores
- ☐ Restless
- ☐ Other_____
- ☐ Wakes up often
- ☐ Loud gasping for breath while sleeping
- ☐ Stops breathing
- ☐ Grinds teeth
- ☐ Becoming very rigid or shaking
- ☐ Biting tongue
- ☐ Kicking during sleep
- ☐ Head rocking or banging
- ☐ Bed-wetting
- ☐ Sleep walking
- ☐ Sleep talking

Comments:_____

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