SLEEP CENTER of the SOUTHWEST

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Pediatric Pulmonary Medicine
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SLEEP CENTER OF THE SOUTHWEST

Accredited by the
AMERICAN ACADEMY OF SLEEP MEDICINE

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THE AMERICAN ACADEMY OF ALLERGY & IMMUNOLOGY
THE AMERICAN COLLEGE OF CHEST PHYSICIANS
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AMERICAN BOARD OF PEDIATRICS (GENERAL PEDIATRICS)
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AMERICAN BOARD OF SLEEP DISORDERS MEDICINE & CLINICAL POLYSOMNOGRAPHY (ADULT & PEDIATRIC)

BED PARTNER QUESTIONNAIRE

NAME: _____ DATE: _____

I have observed this person's sleep:
_____ Never _____ Once or Twice _____ Often _____ Every Night

Check any of the following behaviors that you have observed this person doing while asleep. Circle those that you consider severe problems for this person.

_____ Light snoring
_____ Occasional loud snorts
_____ Pause in breathing
_____ Sleep talking
_____ Bed-wetting
_____ Awakening with pain
_____ Getting out of bed not awake
_____ Becoming very rigid and/or shaking
_____ Apparently sleeping even if he/she Behaves otherwise
_____ Loud snoring
_____ Choking
_____ Twitching or kicking of legs
_____ Grinding teeth
_____ Sitting up in bed not awake
_____ Head rocking or banging
_____ Biting tongue
_____ Crying out
_____ Other (Specify)
_____

If this person snores, what makes it worse?
_____ Sleeping on his/her back
_____ Sleeping on his/her side
_____ Alcohol
_____ Fatigue

Describe the sleep behaviors checked 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. _____
_____
_____

Has this person ever fallen asleep during normal daytime activities or in dangerous situations?
_____ Yes _____ No Explain, if yes _____
_____
_____

Does this person use sleeping pills? _____ Yes _____ No

If yes, how many pills per week
_____ Less then 1/week _____ 1-3/week _____ 4-7/week _____ 7+/week

Do you consider this usage a problem? _____ Yes _____ No _____ Uncertain
Comments: _____

Does this person drink alcohol? _____ Yes _____ No
If yes, this person usually drinks: (Check as many as you believe are appropriate.)
_____ Beer _____ Wine _____ Shots of liquor

Please estimate per week use of:
_____ 12 oz. Bottled/canned tap BEER
_____ 6-8 oz. Glasses of WINE
_____ 1-1 ½ oz. LIQUOR

Please estimate how much this person drinks in the 3 hours before bed. _____

Do you consider this person's drinking a problem? _____ Yes _____ No _____ Uncertain
Comments: _____

If this person uses street drugs, please describe both the types of frequency of usage: _____
_____

Do you believe that this person and yourself share the same understanding about his/her sleep problem, sleeping pill usage, and alcohol/drug usage? _____ Yes _____ No
Comments: _____
_____

IMPORTANT: Has your bed partner ever had an auto, truck, or work related accident caused by his or her sleep disorder? _____ Yes _____ No If yes, explain: _____
_____
_____

Thank you.

_____
Signature

_____
Relationship to patient