Bed Partner Survey

Patient's Name: _____ Date: _____

How likely is your bed partner to doze off or fall asleep in the following situations, in contrast to feeling 'just tired'? This refers to their usual way of life at present and in the recent past. Even if they have not done some of those things recently, try to work out how they would have affected your partner.

Use the following scale to choose the most appropriate number for each situation:

0 = would **never** doze
1 = **slight** chance of dozing
2 = **moderate** chance of dozing
3 = **high** chance of dozing

SITUATION	CHANCE OF DOZING
Sitting and reading	_____
Watching television	_____
Sitting, inactive in a public place (e.g. theatre, meeting)	_____
As a passenger in a car for an hour without a break	_____
Lying down to rest in the afternoon when circumstances permit	_____
Sitting and talking to someone	_____
Sitting quietly after lunch without alcohol	_____
In a car, while stopped for a few minutes in traffic	_____
	TOTAL SCORE: _____

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
- ❒ 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
- ❒ Other

Additional Comments: _____

_____