



BED PARTNER'S (BP) QUESTIONNAIRE FOR EXCESSIVE DAYTIME SLEEPINESS

To the Patient: Please have your BED PARTNER (BP) complete this form. Return it with the other forms.

To the Patient's Bed partner: Please complete this form, giving us YOUR observations of the patient's condition.

PATIENT NAME: _____

Your Name: _____ Today's Date: _____

- 1) What is your BP's problem? (Describe in Detail): _____

- 2) Does you BP snore? Yes _____ No _____
If yes, how long have you known your BP to snore (indicate month, years, etc.)?
- 3) Does he/she snore on his/her:
Back No _____ or Moderately Loud _____ Very Loud _____
Sides No _____ or Moderately Loud _____ Very Loud _____
Stomach No _____ or Moderately Loud _____ Very Loud _____
- 4) Do you consistently sleep in the same bedroom? Yes _____ No _____
If no, why? _____
- 5) How long have you sleep in separate rooms? (indicate months, years, etc) _____
- 6) Does your BP seem to stop breathing in his/her sleep? Yes _____ No _____
If yes, how long has this occurred? (indicate months, years, etc.) _____
If yes, how long are the pauses in breathing? _____
If yes, does he/she gasp for air afterwards? Yes _____ No _____
- 7) Does your BP move around in bed? Yes _____ No _____
If yes, does he/she toss and turn? Yes _____ No _____
If yes, are the movements small, regular, leg movements? Yes _____ No _____
- 8) Does your BP grind his/her teeth in his/her sleep? Yes _____ No _____
- 9) Is your BP sleeper than you most of the time? Yes _____ No _____
If yes, will he/she nap before bedtime? Yes _____ No _____
If yes, how often? _____ days per week or _____ days per month
- 10) Will your BP fall asleep?:
In church Yes _____ No _____
While driving Yes _____ No _____
With company Yes _____ No _____

THANK YOU FOR YOUR COOPERATION