Seattle Sleep Medicine
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To help us with a proper diagnosis and appropriate treatment plan, have your bed partner or a family member complete this questionnaire regarding YOUR sleep habits. This information is vitally important for Dr. Albert to best evaluate your current condition.

Bed Partner Questionaire

Patient's Name: _____ Your Name: _____

☐ Yes ☐ No 1. Do you witness the patient snoring?
☐ Yes ☐ No 2. Do you witness the patient choking or gasping for breath during sleep?
☐ Yes ☐ No 3. Does the patient pause or stop breathing during sleep?
☐ Yes ☐ No 4. Does the patient fall asleep easily, if given the opportunity, during the day (normal wakeful hours)?
☐ Yes ☐ No 5. Do you witness the patient clenching and/or grinding his/her teeth during sleep?
☐ Yes ☐ No 6. Does the patient appear refreshed upon waking?
☐ Yes ☐ No 7. Do the patient's sleep habits disturb your sleep?
☐ Yes ☐ No 8. Does the patient sit up in bed, not awake?

Please check those sleep habits of the patient that are disturbing you:

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

Other _____

How likely is your partner to doze off or fall asleep in the following situations, in contrast to just feeling tired?

This refers to daily life in recent times. If these things have not occurred recently, try to work out how they would have affected your partner.

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

Sitting and reading ____
Watching TV ____
Sitting inactive in a public place (e.g. A theater or a 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 a lunch without alcohol ____
In a car, while stopped for a few moments in traffic ____

0 = Would **never** doze
1 = **Slight** chance of dozing
2 = **Moderate** chance of dozing
3 = **High** chance of dozing

Additional comments regarding the patient's sleep habits not mentioned above:

Many thanks for your help. Please submit using our secure server, or print and have the patient bring to our office.

Print Form