THE REGIONAL CENTER FOR SLEEP MEDICINE
4041 W. Sylvania, Suite 202
Toledo, OH 43623
(419) 292-1616

Bed Partner or Observer Questionnaire

Date: _____ **Patient's Name:** _____

Your name and relationship to the patient: _____

Home Phone #: _____ Work Phone #: _____

How long have you known the patient? ____ How long have you observed the patient's sleep?_____

Why do you think the patient's sleep should be evaluated? _____

_____

Snoring:	**YES**	**NO**
1. Does the patient snore?	☐	☐
If Yes, please answer questions 2 - 7.		
2. Is the snoring loud?	☐	☐
3. Is the snoring irregular: pauses or decreases in volume, followed by gasping?	☐	☐
4. Does the snoring occur only when the patient is lying on their back?	☐	☐
5. Does the snoring occur every night and for the entire night?	☐	☐
6. Is the snoring occasional or infrequent?	☐	☐
7. Does the snoring increase with alcohol intake or increased fatigue?	☐	☐
Other Events during Sleep:		
1. Do the patient's arms or legs jerk during sleep?	☐	☐
2. Does the patient toss or turn restlessly when sleeping?	☐	☐
3. Does the patient sweat heavily while asleep?	☐	☐
4. Does the patient stop breathing while asleep?	☐	☐
5. Has the patient ever vomited when sleeping?	☐	☐
6. Does the patient gag or choke while asleep?	☐	☐
7. Has the patient ever wet the bed as an adult?	☐	☐
8. Has the patient ever turned bluish, grayish, or dusky while asleep?	☐	☐
9. Does the patient appear to "act out" their dreams?	☐	☐
10. Has the patient ever become violent while asleep?	☐	☐
11. Have the patient's eyes ever rolled up while they were sleeping?	☐	☐
12. Does the patient ever scream while sleeping?	☐	☐
13. Has the patient ever fallen out of bed?	☐	☐
14. Does the patient sleepwalk?	☐	☐
If Yes, please answer questions 15 - 17.		
15. While sleepwalking, does the patient seem calm?	☐	☐
16. While sleepwalking, does the patient seem agitated, afraid or excited?	☐	☐
17. While sleepwalking, has the patient ever left the house?	☐	☐

Waking Behaviors:

	YES	NO
1. Does the patient seem very sleepy when awake?	☐	☐
2. Does the patient fall asleep at inappropriate times?	☐	☐
3. Does the patient have difficulty with attention, concentration, or memory?	☐	☐
4. Has the patient ever fallen asleep while driving?	☐	☐
5. Has the patient ever collapsed, fallen, or had sudden muscular weakness following a strong emotion?	☐	☐
6. Does the patient have episodes of staring or "going blank"?	☐	☐
7. Does the patient have episodes of confusion?	☐	☐
8. Does the patient experience "panic attacks"?	☐	☐
9. Has the patient ever experienced a "blackout" or loss of consciousness?	☐	☐
10. Has the patient ever had seizures or convulsions?	☐	☐
11. Does the patient seem depressed or irritable?	☐	☐
12. Does the patient seem to be aware of his or her own sleepiness?	☐	☐

Please rate the patient's:

Quality of Sleep: Poor ☐ Average ☐ Excellent ☐

Level of Alertness: Poor ☐ Average ☐ Excellent ☐