BEFORE / AFTER

Circle One

BED PARTNER QUESTIONNAIRE

Name of person completing this form: _____

Name & Relationship to Patient: _____

I have observed this person's sleep: OFTEN_____ ONLY ONCE OR TWICE_____

CIRCLE ANY OF THE FOLLOWING BEHAVIORS THAT YOU HAVE WITNESSED DURING PATIENT'S SLEEP.

MILD SNORING	**PROFUSE SWEATING**	**THRASHING IN BED**
MODEREATE SNORING	**VIOLENT BEHAVIOR**	**SLEEP WALKING**
SEVERE SNORING	**TOSSING AND TURNING**	**BODY ROCKING**
CHOKING	**PAUSES IN BREATHING**	**BODY ROCKING**
GASPING	**HEAD BANGING**	**BODY SHAKING**
WHEEZING	**LOUD SNORTS**	**EATING THOUGH ASLEEP**
TEETH GRINDING	**KICKING**	**INTERMITTENT BREATHS**
BED WETTING	**RHYTHMIC LEG TWITCHES**	**MORNING HEADACHES**
CRYNG OUT	**WAKING FROM SNORING**	**FREQUENT URINATION**

AWAKENING WITH PAIN **RESTLESS SLEEPER**

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