

Observer/Bed partner Questionnaire

**Please complete this survey to aid in the sleep disorder evaluation.
Answer each question and if unsure, observe. Thank you.**

1) Briefly describe the individual's sleep problems. Indicate how long you have noticed sleep problems and how often.

2) Does he/she snore at night?-----YES NO

If yes, then:

a. Loudly or Quietly (circle one)

b. Periodically or Continuously (circle one)

c. In relation to body position YES NO

If yes, explain:_____

3) Does he/she kick often at night?-----YES NO

If yes, explain:_____

4_ Does he/she have trouble falling asleep at night?-----YES NO

If yes, explain:_____

5) Does he/she fall asleep involuntarily during the day?-----YES NO

If yes, explain:_____

6) Is it hard to wake him/her in the morning?-----YES NO

If yes, explain:_____

7) Does he/she wake frequently at night?-----YES NO

If yes, then:

a. Does he/she wake with a loud snort, gasp, or body jerk? YES NO

b. Does he/she have trouble falling back to sleep after waking? YES NO

8) Does he/she appear to stop breathing at night?-----YES NO

If yes, then:

a. Periodically or frequently. (circle one)

b. In relation to body position? YES NO

c. Almost every night? YES NO

If no, explain:_____

9) Any other comments you would like to make regarding their sleep patterns.
