Bed Partner Survey

Many times, a patient's bed partner (or parent, roommate, etc.) are more aware of a patient's sleep habits than the patient themselves. Please answer the following questions regarding the patient's sleep habits as well as your own.

Patient Name:	Your Name:	Relationship:

Frequency **0-1 days/wk** **1-2 days/wk** **3-4 days/wk** **5-7 days/wk**

How often have you notice the patients, or your own snoring?

Patient: Never (_) Rarely (_) Sometimes (_) Frequently (_) Almost Always (_)
Yourself : Never (_) Rarely (_) Sometimes (_) Frequently (_) Almost Always (_)

How often does the patient or you wake up choking or gasping?

Patient: Never (_) Rarely (_) Sometimes (_) Frequently (_) Almost Always (_)
Yourself: Never (_) Rarely (_) Sometimes (_) Frequently (_) Almost Always (_)

How often does the patient or you have problems keeping your legs still at night?

Patient: Never (_) Rarely (_) Sometimes (_) Frequently (_) Almost Always (_)
Yourself: Never (_) Rarely (_) Sometimes (_) Frequently (_) Almost Always (_)

Epworth Sleepiness Scale
(0=Would Never Doze; 1=Slight Chance of Dozing; 2=Moderate Chance of Dozing; 3=High Chance of Dozing)

How likely is the patient, or are you, to doze off or fall asleep while:

	Patient					Yourself			
Sitting and reading	0	1	2	3		0	1	2	3
Watching TV	0	1	2	3		0	1	2	3
Sitting, inactive, in a public place (theater, meeting, etc)	0	1	2	3		0	1	2	3
As a passenger in a car for an hour without break	0	1	2	3		0	1	2	3
Lying down to rest in the afternoon when circumstances permit	0	1	2	3		0	1	2	3
Sitting and talking to someone	0	1	2	3		0	1	2	3
Sitting quietly after lunch without alcohol	0	1	2	3		0	1	2	3
In a car, while stopped for a few minutes in traffic	0	1	2	3		0	1	2	3

Have ***you*** ever been diagnosed or treated for any of the following conditions?

High blood pressure	Yes (_) No (_)	Stroke	Yes (_) No (_)
Heart disease	Yes (_) No (_)	Depression	Yes (_) No (_)
Diabetes	Yes (_) No (_)	Sleep Apnea	Yes (_) No (_)
Lung disease	Yes (_) No (_)	Nasal oxygen use	Yes (_) No (_)
Insomnia	Yes (_) No (_)	Restless Leg Syndrome	Yes (_) No (_)
Narcolepsy	Yes (_) No (_)	Morning Headaches	Yes (_) No (_)
Sleeping Medication	Yes (_) No (_)	Pain Medication	Yes (_) No (_)

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Signature:_____ Date:_____