# Bed Partner Survey

To help us with a proper diagnosis and appropriate treatment plan, have your bed partner, if applicable and available, fill out this questionnaire regarding YOUR sleep habits. This information is vitally important for Dr. Pham to best evaluate your current condition.

TO BE FILLED OUT BY THE PATIENT'S BED PARTNER

Patient's Name: ______________________________ Date: ________________

2. YES NO Do you witness the patient choking gasping for breath during sleep?

3. YES NO Does the patient pause or stop breathing during sleep?

4. YES NO Does the patient fall asleep easily, if given the opportunity, during the day (normal wakeful hours)?

5. YES NO Do you witness the patient clenching and/or grinding his or her teeth during sleep?

6. YES NO Does the patient appear refreshed upon waking?

7. YES NO Do the patient's sleep habits disturb your sleep?

| | |
|---|---|
| ☐ Snores | ☐ Restless |
| ☐ Loud gasping for breath while sleeping | ☐ Wakes up often |
| ☐ Stops breathing | ☐ Grinds teeth |
| ☐ Becoming very ridged or shaking | ☐ Biting Tongue |
| ☐ Kicking during sleep | ☐ Bed-wetting |
| ☐ Head rocking or banging | ☐ Sleep-walking |
| ☐ Sleep Talking | Other: |