Lexington Sleep Solutions

LexingtonSleepSolutions.com

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Lexington Health

Bed Partner Questionnaire

Patient Name: _____ Date: _____

Completed By: _____ Date: _____

Check any of the following behaviors that you have observed the patient doing while asleep.

- ☐ Loud snoring
- ☐ Light snoring
- ☐ Twitching of legs or feet during sleep
- ☐ Pause in breathing
- ☐ Grinding teeth
- ☐ Sleep talking
- ☐ Bed wetting
- ☐ Sitting up in bed but not awake
- ☐ Head rocking or banging
- ☐ Kicking with legs during sleep
- ☐ Getting out of bed but not awake
- ☐ Biting tongue
- ☐ Becoming very rigid and/or shaking

How long have you been aware of the sleep behavior(s) that you checked above? _____

_____

_____

Describe the behavior checked above in more detail. Include a description of the activity, the time during the night when it occurs, frequency during the night and whether it occurs every night. _____

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If you have heard loud snoring, do you remember pauses in the snoring or occassional loud “snorts”? Describe._____

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