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Bed Partner Questionnaire

Na	me: Date:
Re	lationship to patient:
Pa	tient Name:
1.	How frequently do you observe this person's sleep?
2.	Does this person snore? If "yes", please complete A, B, and C. A. How many nights on average during the week does this person snore? B. Describe this person's snoring: please check all that apply.) Loud Moderate Light Periodic Continuous C. In what sleeping position does he/she seem to snore louder or more frequently? Back Left side Right side Stomach Does not matter
3.	Does this person seem to stop breathing during sleep?
4.	Does this person seem to grind their teeth during sleep?
5.	Has this person fallen asleep when they deny or are not aware that they are sleeping?
6.	Do you feel this person has become less alert than they were in the past?
7.	Has this person become less patient or more irritable than they were in the past?
8.	Does this person kick their legs or move frequently during the night?
9.	Does this person talk in their sleep? If "yes", how often?
des	Does this person ever sit up or get out of bed while apparently asleep? If "yes", cribe these episodes
	Does this person ever have body shakes or get rigid in their sleep?
12.	Does this person use sleeping pills? If "yes", what kind, how often?
13.	Does this person drink alcohol? If "yes", how much, how often?
	ase add any additional comments that you feel are important about this person's sleep or time functions that may be related to sleep problems