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 sleeping habits. This information is vitally important to Dr. Denson to best evaluate your current condition

TO BE FILLED OUT BY THE PATIENT'S BED PARTNER

	YES		NO	Do you witness the patient snoring?
	YES		NO	Do you witness the patient choking or gasping for breath during sleep?
	YES		NO	Does the patient pause or stop breathing during sleep?
	YES		NO	Does the patient fall asleep easily if given the opportunity, during the day (normal wakeful hours)
	YES		NO	Do you witness the patient clenching and/or grinding his/her teeth during sleep?
	YES		NO	Does the patient appear refreshed upon waking?
	YES		NO	Do the patient's sleep habits disturb your sleep?
	YES		NO	Does the patient sit up in bed not awake?

PLEASE CHECK THOSE SLEEP HABITS OF THE PATIENT THAT ARE DISTURBING YOU

	Snores
	Restless
	Wakes up Often
	Loud gasping for breath while sleeping
	Stops breathing
	Grinds Teeth
	Becoming very rigid or shaking
	Biting tongue
	Kicking during sleep
	Head rocking or banging
	Bed Wetting
	Sleepwalking or Sleepwalking