Bed Partner/Witness Screening Questionaire: Obstructive Sleep Apnea

Name:_____

Person completing form:_____ Date:____/____/____

Please answer the following questions as they pertain to your bed partner in the past month.

1. While sleeping, does your partner:

Snore more than half the time?.....Y N DK
Always snore?.....Y N DK
Snore loudly?.....Y N DK
Have "heavy" or loud breathing?.....Y N DK
Have trouble breathing, or struggle to breathe?.....Y N DK

2. Have you ever seen your partner stop breathing during the night?.....Y N DK

3. Does your bed partner ever have snorting or choking episodes during the night?.....Y N DK

4. Does your partner:

Tend to breathe through the mouth?.....Y N DK
Have a dry mouth on waking up in the morning?..... .Y N DK
Occasionally wet the bed?.....Y N DK

5. Have you ever experienced your partner:

Grinding their teeth during the night?.....Y N DK
Have twitching or kicking of their legs or arms?.....Y N DK

6. Does your partner:

Wake up feeling unrefreshed in the morning?.....Y N DK
Have a problem with sleepiness during the day?.....Y N DK

7. Has a friend, coworker or supervisor commented that your partner appears sleepy during the day?.....Y N DK

8. Is it hard to wake your partner up in the morning?.....Y N DK

9. Does your partner wake up with headaches in the morning?.....Y N DK

10. Is your partner overweight?.....Y N DK