Mercy Neurodiagnostic Sleep Center
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Bed Partner Questionnaire

Name of patient: _____ Date: _____

Name/relationship of person filling out this form: _____

Please describe any sleep behaviors you have observed in detail. Include a description of the activity, the time during the night when it occurs, frequency of occurrence:

_____

_____

_____

_____

_____

_____

Has this person ever fallen asleep during normal daytime activities or in dangerous situations?

❒ Yes ❒ No If yes, please explain: _____

_____

_____

_____

Does this person snore? _____ Describe: _____

Do you have concerns with this person?:

Breathing in sleep? ❒ Yes ❒ No

Restlessness during sleep? ❒ Yes ❒ No

Sleepwalking/talking in sleep? ❒ Yes ❒ No

Becoming very rigid or shaking during sleep? ❒ Yes ❒ No

Additional Comments: