# Dental Sleep Therapy

## Bed Partner Questionnaire

To be completed by the Patient's Bed Partner, without influence of the Patient.
Please complete and have the patient bring with them to their sleep study appointment.

Patient's Name: _____ Date: _____

Relationship to Patient: _____

Please estimate how many hours of sleep your bed partner gets:

| Sleep Schedule: | Hours Each Night: | How Long does it take to fall asleep? | How Long is your partner awake during the night? |
|---|---|---|---|
| Work Days: | | | |
| Days Off: | | | |

Mark any positions your bed partner sleeps in: ____ Back ____ Side ____ Stomach

Does your partner snore? ____ Never ____Occasionally ____ Often ____ Unknown

If they snore, please mark the positions they snore in: ____ Back ____ Side ____ Stomach

How loud is her/his snoring? ___1 (Light) ___ 2 ___ 3 ___ 4 ___ 5 (Loud)

Does your bed partner do any of the following in his/her sleep? (Please mark all that apply)

___ Gagging ___ Choking ___ Snoring ___ Gasping ___ Teeth Grinding ___ Kicking their Feet

| | Never | Occasionally | Often | Unknown |
|---|---|---|---|---|
| Does your bed partner take naps during the day? | | | | |
| Does your bed partner stop breathing in his/her sleep? | | | | |
| Does your bed partner fall asleep when driving? | | | | |
| Does he/she fall asleep without warning? | | | | |
| Does your bed partner kick their legs while sleeping? | | | | |
| Does your bed partner mumble, talk, or yell during sleep? | | | | |

Does your bed partner awaken during the night? ___ Never ___ Occasionally ___ Often ___ Unknown

If awaken, how long does it take them to get back to sleep? Hrs.: ____ Mins: ____ ____ Unknown

Do you know why he/she awakens? ___ Yes ___ No If yes, why?_____

_____

Does your bed partner's sleep problems disrupt your sleep? ___ Never ___ Occasionally ___ Often

How Much Stress does your bed partner currently have? ___1 (Light) ___ 2 ___3 ___4 ___ 5 (High)

Please use this space for any other information you would like to share.