Bed Partner / Witness Screening Questionnaire: 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