

◆ **OBSERVERS / BED PARTNERS SURVEY** ◆

Please complete this survey to aid in the sleep disorder evaluation. Answer each question and if unsure, observe. Thank You.

- 1.) Briefly describe the individual's sleep problems. Indicate how long you have noticed sleep problems and how often.

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- 2.) Does he/she snore at night? Yes      No

If yes, then:

a.) Loudly      or      Quietly      (circle one)

b.) Periodically      or      Continuously      (circle one)

c.) In relation to body position?

If yes, please explain

- 3.) Does he/she kick often at night? Yes      No

If yes, please explain

- 4.) Does he/she have trouble falling asleep at night? Yes      No

If yes, please explain

- 5.) Does he/she fall asleep during quiet activities? Yes      No

If yes, please explain

- 6.) Is it hard to wake him/her in the morning? Yes      No

If yes, please explain

- 7.) Does he/she wake frequently at night? Yes      No

If yes, please explain

a.) Does he/she wake with a loud snort, gasp, or body jerk? Yes      No

b.) Does he/she have trouble falling back to sleep after waking? Yes      No

- 8.) Does he/she appear to stop breathing at night? Yes      No

If yes, please explain

a.) Periodically      or      Frequently      (circle one)

b.) In relation to body position? Yes      No

c.) Almost every night? Yes      No

If no, please explain

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