BAHAMAS NEUROLOGICAL CENTER, INC.
#10 Caves Village, West Bay Street
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Bed-Partner Questionnaire

Name (Last, First, M.I.):_____ □M □F Date: _____

Name of person filling out this form:_____

I have observed this patient's sleep behavior: □Never □Once/Twice □Often □Every Night

Check any of the following behaviors that you have observed this person doing while asleep:

□Light snoring □Loud snoring occasional snorts □Choking

□Pauses in breathing □Twitching/kicking of legs during sleep □Bed wetting

□Biting tongue □Getting out of the bed but not awake □Crying out

□Other □Sitting up in bed not awake

□Becoming very rigid and/or shaking □Apparently sleeping even if he/she behaves otherwise

Please describe the sleep behaviors checked above in more detail. Include a description of the activity, the time during the night when it occurs frequently during the night, and whether it occurs every night.

Has this person ever fallen asleep during normal daytime activities or in dangerous situations? If yes, please explain.