Dental Sleep Solutions of Maryland LLC

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 appointment.

Patient's Name:_____ Date:_____

Your relationship to Patient:_____

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

Sleep Schedule:	**Hours each night:**	**How long does it take for your partner to fall asleep?**	**How long is your partner awake during the night?**
Work days:			
Days off:			

Check any positions your bed partner sleeps in: ☐ Back ☐ Side ☐ Stomach

Does your bed partner snore? ☐ Never ☐ Occasionally ☐ Often ☐ Unknown

If they snore, please check the positions they snore in: ☐ Back ☐ Side ☐ Stomach

How loud is his/her snoring? ☐ 1 (Light) ☐ 2 ☐ 3 ☐ 4 ☐ 5 (Loud)

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

☐ Gagging ☐ Chocking ☐ Snorting ☐ Gasping ☐ Teeth Grinding ☐ Kicking their feet

	Never	Occasionally	Often	Unknown
Does your bed partner take naps during the day?				
Is your bed partner restless during sleep?				
Does your bed partner stop breathing in his/her sleep?				
Does your bed partner fall asleep when driving?				
Does your bed partner 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?				