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THE FINEST DENTISTRY - MADE AFFORDABLE

Bed Partner/Witness Screening Questionnaire: Obstructive Sleep Apnoea

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 partner ever have snorting or chocking 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 we the bed?..Y N DK

5. Have you ever experienced you 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, co-worker or supervisor commented that your partner appears sleepy during the day?...Y N DK

8. Is it hard to wake your partner 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

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