



**PULMONARY
MEDICINE
ASSOCIATES**

Sleep Center
Spouse or Roommate Questionnaire

Patient: _____ Date: _____

Check any of the behaviors that you have observed the patient doing while asleep.

- | | |
|---|--|
| <input type="checkbox"/> Loud snoring | <input type="checkbox"/> Bed-wetting |
| <input type="checkbox"/> Light snoring | <input type="checkbox"/> Sitting up in bed, not awake |
| <input type="checkbox"/> Twitching of legs or feet during sleep | <input type="checkbox"/> Head rocking or banging |
| <input type="checkbox"/> Pause in breathing | <input type="checkbox"/> Kicking with legs during sleep |
| <input type="checkbox"/> Grinding teeth | <input type="checkbox"/> Getting out of bed, but not awake |
| <input type="checkbox"/> Sleep talking | <input type="checkbox"/> Biting tongue |
| <input type="checkbox"/> Sleep walking | <input type="checkbox"/> Becoming very rigid or shaking |

Any other unusual behaviors:

How long have you been aware of these sleep behaviors?

Please describe the activity. Include time during the night when it occurs, frequency during the night, and whether it occurs every night:

If you've noticed loud snoring, did you hear short pauses in the snoring or occasional loud snorts?