

# 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 sleep study appointment.

Patient's Name: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

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

<b>Sleep Schedule:</b>	<b>Hours Each Night:</b>	<b>How Long does it take to fall asleep?</b>	<b>How long is your partner awake during the night?</b>
<b>Work Days:</b>			
<b>Days Off:</b>			

Mark any positions your bed partner sleeps in:     Back     Side     Stomach

Does your bed partner snore?     Never     Occasionally     Often     Unknown

If they snore, please mark 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? (Please mark all that apply)

Gagging     Choking     Snorting     Gasping     Teeth Grinding     Kicking their feet

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

If they awaken, how long does it take them to get back to sleep? Hrs: \_\_\_\_\_ Mins: \_\_\_\_\_     Unknown

Do you know why he/she awakens?     Yes     No    If yes, Why? \_\_\_\_\_

Is your bed partner restless during sleep?     Never     Occasionally     Often     Unknown

Describe what they do when restless: \_\_\_\_\_

\_\_\_\_\_



Please complete the entire form and sign at the  
bottom on the second page.

Patient Name: \_\_\_\_\_  
Last First Middle Initial

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip code: \_\_\_\_\_

Email Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Daytime Phone: \_\_\_\_\_

Sex:  Female  Male Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ SSN# : \_\_\_\_\_

Marital Status:  Single  Married  Divorced  Widowed

Employer: \_\_\_\_\_ Phone#: \_\_\_\_\_

### Responsible Party Information

Same as above

Relationship to Patient:  Spouse  Child  Other \_\_\_\_\_

Resp Part Name: \_\_\_\_\_  
Last First Middle Initial

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Sex:  Female  Male Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ SSN# : \_\_\_\_\_

Marital Status:  Single  Married  Divorced  Widowed

Employer: \_\_\_\_\_ Phone#: \_\_\_\_\_

### Emergency Contact Information

Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Relationship: \_\_\_\_\_

**Primary Insurance Information**

Name Of Carrier: \_\_\_\_\_

Telephone Number: \_\_\_\_\_ ID# \_\_\_\_\_

Group Name: \_\_\_\_\_ Group # \_\_\_\_\_

Policy Holder's Name: \_\_\_\_\_  
Last First Middle Initial

Policy Holder's Date Of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Holder's SSN#: \_\_\_\_\_

**Secondary Insurance Information**

Name Of Carrier: \_\_\_\_\_

Telephone Number: \_\_\_\_\_ ID# \_\_\_\_\_

Group Name: \_\_\_\_\_ Group # \_\_\_\_\_

Policy Holder's Name: \_\_\_\_\_  
Last First Middle Initial

Policy Holder's Date Of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Holder's SSN#: \_\_\_\_\_

**\*\*\*\*\* NOTICE \*\*\*\*\***

I understand that the information collected is for billing purposes only and that it is my responsibility to keep Advanced Sleep Disorder Center updated with any changes in my insurance coverage and/or (address, telephone number, ect.) contact status.

I understand that Advanced Sleep Disorder Center,LLC will bill my insurance carrier and that I am responsible for all deductibles, co-payments, and any balance after insurance has paid. I understand that if I do not provide proof of insurance at the time of service, that I will be billed directly and am legally liable for paying the entire amount of my account.

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

## Patient Questionnaire

**Please make sure to bring this completed to your sleep study**

Patient: \_\_\_\_\_ DOB: \_\_\_\_\_

Reason for sleep evaluation: \_\_\_\_\_

How long have you had this problem? \_\_\_\_\_

Check any of the boxes that you have experienced in the past 6 months:

<input type="checkbox"/> Night Sweats	<input type="checkbox"/> Heat or Cold Intolerance	<input type="checkbox"/> Chest Discomfort
<input type="checkbox"/> Weight Gain / Loss	<input type="checkbox"/> Coughing or Wheezing	<input type="checkbox"/> Rapid Heart Beat
<input type="checkbox"/> Passing Out	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Leg / Feet Swelling
<input type="checkbox"/> Numbness / Tingling	<input type="checkbox"/> Muscle Aches and Cramps	<input type="checkbox"/> Trouble Breathing
<input type="checkbox"/> Headache	<input type="checkbox"/> Heartburn	<input type="checkbox"/> Sinus Congestion
<input type="checkbox"/> Depression	<input type="checkbox"/> Frequent Urination	<input type="checkbox"/> Nausea or Vomiting
<input type="checkbox"/> Weak muscles when telling or hearing a joke	<input type="checkbox"/> Heard or seen things that were not there (as if dreaming, but awake) when walking or falling asleep	<input type="checkbox"/> Felt as if you could not move when waking or falling asleep
<input type="checkbox"/> Back Pain	<input type="checkbox"/> Other:	<input type="checkbox"/> None

Please list all your medications, including over-the-counter meds and herbal remedies:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do you have any allergies to medicine? If so, please list them: \_\_\_\_\_

Do you have a history of: (Please check all boxes that apply)

<input type="checkbox"/> Stroke or TIA	<input type="checkbox"/> Seizures/Other Neurological Diseases	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Drug or Alcohol Addiction	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Depression
<input type="checkbox"/> Thyroid Issues	<input type="checkbox"/> Deviated Nasal Septum	<input type="checkbox"/> Lung Disease	<input type="checkbox"/> Anxiety

Past or Current Medical Problems: \_\_\_\_\_

Past Surgeries: \_\_\_\_\_

Have you had your tonsils removed?  Yes  No If so, at what age? \_\_\_\_\_

Occupation: \_\_\_\_\_

Do you work shift work? If so, what shifts? \_\_\_\_\_

Do you smoke?  Yes  No If so, for how many years and how much? \_\_\_\_\_

Do you drink Alcohol?  Yes  No If so, how many drinks per week? \_\_\_\_\_

Do you drink coffee, caffeinated soda, or tea?  Yes  No If so, how many cups per day? \_\_\_\_\_

Is there anyone in your family with the following conditions?

<input type="checkbox"/> Seizures	<input type="checkbox"/> Dementia	<input type="checkbox"/> Excessive Sleepiness	<input type="checkbox"/> Parkinson's Disease
<input type="checkbox"/> Narcolepsy	<input type="checkbox"/> Insomnia	<input type="checkbox"/> Sleep Apnea	<input type="checkbox"/> None

If you marked any of the above conditions please list relationship to effected person: \_\_\_\_\_

Please mark any of the below occurrences that either you or someone else has observed of you:

<input type="checkbox"/> Snoring	<input type="checkbox"/> Acting Out Dreams	<input type="checkbox"/> Wake Up Gasping For Air
<input type="checkbox"/> Leg Jerks	<input type="checkbox"/> Nighttime Wheezing	<input type="checkbox"/> Stop Breathing While Sleeping
<input type="checkbox"/> Restless Sleep	<input type="checkbox"/> Vivid Dreams/Nightmares	<input type="checkbox"/> Take Sleeping Medication
<input type="checkbox"/> Talking In Sleep	<input type="checkbox"/> Morning Headaches	<input type="checkbox"/> Creeping/Crawling Feeling In Legs
<input type="checkbox"/> Teeth Grinding	<input type="checkbox"/> Sleep Disrupting Ideas	<input type="checkbox"/> Feel The Need To Move Your Legs
<input type="checkbox"/> Sleep Walking	<input type="checkbox"/> Awaken With Dry Mouth	<input type="checkbox"/> Pain That Interferes With Sleep

Is your Nighttime sleep refreshing?  Yes  No

Are you sleepy/fatigued during the day?  Yes  No If yes, what time of day is worse? \_\_\_\_\_

If you snore, what sleeping positions do you snore in?  Back  Side  Stomach

Does your snoring disturb others?  Yes  No

What positions do you sleep in:  Back  Side  Stomach

Mark any of the following that you do while you are in bed:

Read  Eat  Watch TV  Do work activities  Sleep with the TV on

How many times do you wake to use the restroom? \_\_\_\_\_

How long does it take you to fall back to sleep? \_\_\_\_\_ If you have difficulty falling asleep, what do you do? \_\_\_\_\_

Do you take naps?  Yes  No If yes, how long are they? \_\_\_\_\_

Do you dream during the naps?  Yes  No Are the naps refreshing?  Yes  No

Do you exercise?  Yes  No If yes, what time of day do you exercise? \_\_\_\_\_

Estimate your risk of falling asleep or dozing off in the following situations, using the following scale:

0 = No chance      1= Slight chance      2= Moderate chance      3= High chance

Sitting and reading : <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	Lying down to rest in the afternoon : <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3
Watching TV : <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	As a passenger in a car, for an hour, with no break : <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3
Sitting, inactive, in public (Theater, Meetings, Etc.) : <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	Sitting quietly after lunch, without Alcohol: <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3
Sitting and talking to someone: <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	In a car, stopped in traffic, for a few minutes: <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3

<b>Sleep Schedule:</b>	<b>Bedtime:</b>	<b>Rise Time:</b>	<b>How long to fall asleep</b>
<b>Work Days</b>			
<b>Days Off</b>			