Bed Partner/Witness Screening Questionnaire:

Obstructive Sleep Apnea

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:

   Tend to breathe through the mouth during the day?………………. Y N DK
   Have a dry mouth on waking up in the morning?………………….. Y N DK
   Occasionally wet the bed?……………………………….…………… Y N DK

4. Does your partner:

   Wake up feeling unrefreshed in the morning?………….…………… Y N DK
   Have a problem with sleepiness during the day? ………………….. Y N DK

5. Has a friend, coworker or supervisor commented that your partner appears sleepy during the day?……………… Y N DK

6. Is it hard to wake your partner up in the morning? ………… Y N DK

7. Does your partner wake up with headaches in the morning? Y N DK

8. Is your partner overweight? ………………………………………………………… Y N DK
Scoring

Yes = 1
No = 0

Average all scores to obtain a score between 0.00 and 1.00. Preliminary analyses suggest a cut-off of >0.33 for abnormal.