Northfield Hospital + Clinics

Spouse or Roommate Questionnaire

Patient name:_____ Date:_____

What is your relationship to the patient named above: _____

Check any of the following behaviors that you have observed the patient do while he\she is asleep.

_____ Loud Snoring
_____ Light Snoring
_____ Twitching of Legs or Feet During Sleep
_____ Pauses in Breathing
_____ Grinding Teeth
_____ Sleeptalking
_____ Sleepwalking
_____ Bed Wetting
_____ Sitting Up in Bed but Not Awake
_____ Head Rocking or Banging
_____ Kicking with Legs During Sleep
_____ Getting Out of Bed but Not Awake
_____ Biting Tongue
_____ Becoming Very Rigid and\or Shaking

How long have you been aware of the sleep behavior(s) checked above? _____

Describe the behavior(s) checked above in more detail. Include a description of the activity, the time during the night when it occurs, its frequency during the night, and whether it occurs every night.

_____

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_____

If you heard loud snoring, do you remember hearing short pauses in the snoring or occasional loud "snorts"?_____

Thank you for completing this form!

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