harpenden orthodontics

Questionnaire for Sleeping Partner

We are looking to see whether your partner has problems with their breathing during their sleep. Your answers may be shared with your sleeping partner and in strict confidence.

Please tick the box if you DO NOT wish your answers to be shared with your sleeping partner ☐

Your Name: _____ Partners Name: _____ Date: _____

1. Does your partner stop breathing during their sleep? Yes No

If they do, how many times a night does this happen? (Circle answer) Yes No

1-10 11-20 more than 20 times

2. Is your partner very restless in their sleep? Yes No

3. Does your partner snore very loudly in their sleep? Yes No

4. Has the noise been so bad that you have to sleep in another room? Yes No

5. Has your partner's personality changed lately? Yes No

If so, in what way? _____

6. Does your partner fall asleep during the day? Yes No

7. Has your partner ever fallen asleep when driving a vehicle? Yes No

How likely is your partner to doze off or fall asleep n the following situations, in contrast to feeling just tired? This refers to their usual way of life. Even if they haven't done some of these things recently, try and work out how they would be affected.

Use the following scale to choose the most appropriate number to each situation:

0 = never doze, 1 = slight chance of dozing, 2 = moderate chance, 3 = high chance of dozing

Situation	Chance of Dozing (Circle Answer)			
Sitting and reading	0	1	2	3
Watching TV	0	1	2	3
Sitting, inactive in a public place (e.g a theatre or a meeting)	0	1	2	3
As a passenger in a car for an hour without a break	0	1	2	3
Lying down to rest in the afternoon when circumstances permit	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after lunch without alcohol	0	1	2	3
In a car, while stopped for a few minutes in the traffic.	0	1	2	3