

Klamath Pulmonary & Critical Care Medicine

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SLEEP DISORDERS LAB

SPOUSE OR ROOMMATE QUESTIONNAIRE

Name of Patient _____ Date _____

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

While Asleep

While Awake

- | | |
|---|--|
| <input type="checkbox"/> loud snoring | <input type="checkbox"/> depression |
| <input type="checkbox"/> light snoring | <input type="checkbox"/> change in personality |
| <input type="checkbox"/> twitching of legs or feet | <input type="checkbox"/> loss of intellectual function |
| <input type="checkbox"/> pauses in breathing | <input type="checkbox"/> excessive daytime sleepiness |
| <input type="checkbox"/> grinding teeth | <input type="checkbox"/> weight gain |
| <input type="checkbox"/> sleep talking | <input type="checkbox"/> fatigue |
| <input type="checkbox"/> sleep walking | <input type="checkbox"/> morning headache |
| <input type="checkbox"/> bed wetting | <input type="checkbox"/> irritability |
| <input type="checkbox"/> sitting up in bed not awake | |
| <input type="checkbox"/> kicking of the legs | |
| <input type="checkbox"/> getting out of bed not awake | |

How long have you been aware of the sleep behaviors that you checked above?

Describe the sleep behaviors described above in more detail. Include the type of activity, the time of night in which it occurs, frequency during the night and whether it occurs every night.

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