Email Submit

Bed Partner Survey

Cahill DENTAL CARE
Dental Solutions for Restful Sleep

Date: _____

Patient Name: _____

Please fill in the survey below. You can open it in Adobe Reader and place an "X" in the appropriate location. After you have filled it out you can either print it and bring it to your appointment or save it and email it back to us. If you have any questions please call the office at 651-451-9101.

Please place an "X" in the appropriate Yes/No area of each question:

Yes	No	
☐	☐	Can you hear snoring during the night?
☐	☐	Do you witness gasping or choking during sleep?
☐	☐	Is there a pause or stoppage of breathing during sleep?
☐	☐	Does the patient fall asleep easily?
☐	☐	Will your bed partner nap if given the opportunity?
☐	☐	Is there any grinding or clenching of teeth during sleep?
☐	☐	In the morning does you bed partner awaken refreshed?
☐	☐	Are your sleep habits disturbed?
☐	☐	Does your bed parner sit up in bed not awake?

Please check the sleep habits that are disturbing to you:

_____ Snores
_____ Restless
_____ Loud Gasping/Chocking
_____ Stoppage of Breath
_____ Grinding of Teeth
_____ Kicking
_____ Head Rocking
_____ Wakes Up Often
_____ Sleep Walking/Talking
_____ Bed Wetting

How likely is your partner to fall asleep in the following situations:

Never	Slight	Moderate	High	
☐	☐	☐	☐	Sitting and reading
☐	☐	☐	☐	Watching TV
☐	☐	☐	☐	As a passenger in a car form more than 1 hour
☐	☐	☐	☐	Lying down in the afternoon
☐	☐	☐	☐	Sitting and talking to someone
☐	☐	☐	☐	Sitting after lunch without alcohol
☐	☐	☐	☐	In a car stopped in traffic for awhile