RIVERSIDE
Neurology & Sleep Specialists
A Department of Riverside Regional Medical Center

❑ **Williamsburg Office**
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❑ **Gloucester Office**
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OBSERVER QUESTIONNAIRE

This form can be completed by anyone who knows the patient's sleep habits well – spouse, family member, significant other, etc…

Patient name: _____ Date: _____

Name of person completing form: _____ Relationship to patient: _____

I have observed this person's sleep: ☐ rarely ☐ occasionally ☐ often ☐ every night

Please check the appropriate box for the following symptoms:

	None	Rarely	Occasionally	Frequently
Snoring				
Snorting				
Pauses in breathing				
Choking / gasping				
Sleepiness when sitting quietly				
Driving sleepiness				
Leg twitches				
Leg cramps				
Cold feet				
Hard to awaken				
Acting out dreams				
How often does the patient's snoring force you to sleep separately?				

If the patient snores, what makes it worse? ☐ alcohol ☐ fatigue ☐ sleeping on back

Any other pertinent information?

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