SLEEP OBSERVER SCALE

This form is to be completed by your bed partner.

Patient's Name: _____

Observer's Name: _____ Date: _____

The following questions relate to *the behavior that you have observed* in this patient while he/she is asleep. Use the following scale to choose the most appropriate number for each situation.

0 = Never
1 = Infrequently (one night per week)
2 = Frequently (two to three nights per week)
3 = Most of the time (four or more nights per week)

Behavior Observed

Loud, obtrusive or irritating snoring _____

Chocking or gasping for air _____

Pauses in breathing _____

Twitching/kicking of arms or legs _____

Snoring requiring separate bedrooms _____

Falling asleep inappropriately _____
(example: while driving or in meetings)

TOTAL SCORE: _____

A score of 5 or greater indicates symptoms affecting the health, safety, or quality of life of the observed person.