**SLEEP OBSERVER SCALE**
**(Significant other to fill out)**

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|---|
| 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.

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|---|
| 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) |

| | SCORE |
|---|---|
| Loud, obtrusive or irritating snoring | |
| Choking or gasping for air | |
| Pauses in breathing | |
| Twitching or kicking of arms or legs | |
| Snoring requiring separate bedrooms | |
| Falling asleep inappropriately (e.g., while driving or in meetings) | |
| | TOTAL: |

***Please note that a score of 5 or greater indicates symptoms affecting the health, safety, or quality of life of that observed person.***