



## BERLIN QUESTIONNAIRE SLEEP EVALUATION

1. Please complete the following:

Height \_\_\_\_\_ Age \_\_\_\_\_  
Weight \_\_\_\_\_ M/F \_\_\_\_\_

2. Do you snore?

- Yes
- No
- Don't know

*If you snore:*

3. Your snoring is?

- Slightly louder than breathing
- As loud as talking
- Louder than talking
- Very loud. Can be heard in adjacent rooms.

4. How often do you snore?

- Nearly every day
- 3-4 times a week
- 1-2 times a week
- 1-2 times a month
- Never or nearly never

5. Has your snoring ever bothered other people?

- Yes
- No

6. Has anyone noticed that you quit breathing during your sleep?

- Nearly every day
- 3-4 times a week
- 1-2 times a week
- 1-2 times a month
- Never or nearly never

7. How often do you feel tired or fatigued after your sleep?

- Nearly every day
- 3-4 times a week
- 1-2 times a week
- 1-2 times a month
- Never or nearly never

8. During your waketime, do you feel tired, fatigued or not up-to-par?

- Nearly every day
- 3-4 times a week
- 1-2 times a week
- 1-2 times a month
- Never or nearly never

9. Have you ever nodded off or fallen asleep while driving?

- Yes
- No

*If yes, how often does it occur?*

- Nearly every day
- 3-4 times a week
- 1-2 times a week
- 1-2 times a month
- Never or nearly never

10. Do you have high blood pressure?

- Yes
- No
- Don't know

category 1

category 2

category 3

(For office use)

Scoring Questions: Any answer within the box outline is a positive response.

Scoring categories:

- Category 1 is positive with 2 or more positive responses to questions 2-6
- Category 2 is positive with 2 or more positive responses to questions 7-9
- Category 3 is positive with 1 positive response and/or BMI>30

Final Result: 2 or more possible categories indicates a high likelihood of sleep disordered breathing.

(BMI=Body Mass Index)

Patient Signature \_\_\_\_\_

Date \_\_\_\_\_



# EPWORTH SLEEPINESS SCALE

How likely are you to fall asleep in the following situations?

- 0 = Would never doze
- 1 = Slight chance of dozing
- 2 = Moderate chance of dozing
- 3 = High Chance of dozing

<u>ACTIVITY</u>	<u>SCORE</u>
Sitting and Reading	_____
Watching television	_____
Sitting, inactive, in a public place (theater, meeting, etc.)	_____
As a passenger in a car for an hour with no break	_____
Lying down to rest in the afternoon, if circumstances permit	_____
Sitting and talking to someone	_____
Sitting quietly after lunch without alcohol	_____
In a car while stopped for a few minutes in traffic	_____
<b><u>TOTAL SCORE:</u></b>	_____

A score of ten or above indicates you may be having a problem with daytime sleepiness. However, below ten does not necessarily mean you do not have a problem.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date