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 wake time, 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

(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