OAK PARK DENTAL

Enhancing your life, health and smile.

BERLIN QUESTIONNAIRE SLEEP EVAULATION

1. Please complete the following:

Height _____ Age _____

Weight _____ M/F _____

category 1

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

category 2

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

category 3

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 _____

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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

ACTIVITY	SCORE
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	_____
TOTAL SCORE:	_____

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 _____