

# BERLIN QUESTIONNAIRE

*and Sleep Evaluation*

Please complete the following:

1).  
 Height: \_\_\_\_\_ D.O.B.: \_\_\_\_\_  
 Weight: \_\_\_\_\_ Male/Female: \_\_\_\_\_

Cat. I

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**

4). How often do you snore?  
 **ALMOST EVERY DAY**  
 **3-4 TIMES A WEEK**  
 1-2 times a week  
 Never or almost never

5). Does your snoring bother other people?  
 YES  
 No

6). Has anyone noticed that you quit breathing during your sleep?  
 **ALMOST EVERY DAY**  
 **3-4 TIMES A WEEK**  
 1-2 times a week  
 Never or almost never

Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_  
 State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Phone: \_\_\_\_\_

Cat. II

7). Are you tired after sleeping?  
 **ALMOST EVERY DAY**  
 **3-4 TIMES A WEEK**  
 1-2 times a month  
 Never or almost never

8). Are you tired during wake time?  
 **ALMOST EVERY DAY**  
 **3-4 TIMES A WEEK**  
 1-2 times a month  
 Never or almost never

9). Have you ever nodded off or fallen asleep while driving?  
 YES  
 No

If yes, how often does it occur?  
 **EVERY DAY**  
 **3-4 TIMES A WEEK**  
 1-2 times a week  
 1-2 times a month  
 Never or almost never

Cat. III

10). Do you have high blood pressure?  
 YES  
 No  
 Don't know

BMI = \_\_\_\_\_

**Category I** (questions 2-6)

High Risk  2 or more positive responses  
(answers in **BOLD CAPS**)

**Category II** (questions 7-9)

High Risk  2 or more positive responses  
(answers in **BOLD CAPS**)

**Category III** (question 10)

High Risk  A YES response and/or  
BMI > 30

**Final Results:**

2 or more checked categories  
indicates **high likelihood of**  
sleep apnea