BERLIN QUESTIONAIRE SLEEP EVALUATION

1. Complete the following:
   Height: _____ Age:_____
   Weight: _____ Gender: _____
   Has your weight changed? _____

2. Do you snore?
   - ☐ **Yes**
   - ☐ No
   - ☐ Don't know

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 night**
   - ☐ **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 night**
   - ☐ **3-4 times a week**
   - ☐ 1-2 times a week
   - ☐ Never or almost never

7. Are you tired after sleeping?
   - ☐ **Almost every day**
   - ☐ **3-4 times a week**
   - ☐ 1-2 times a week
   - ☐ Never or almost never

8. Are you tired during waketime?
   - ☐ **Almost every day**
   - ☐ **3-4 times a week**
   - ☐ 1-2 times a week
   - ☐ 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

10. Do you have high blood pressure?
    - ☐ **Yes**
    - ☐ No
    - ☐ Do not know

Category 1. (Questions 2-6) 2 or more positive responses (in bold type) = ☐ HIGH RISK

Category 2. (Questions 7-9) 2 or more positive responses (in bold type) = ☐ HIGH RISK

Category 3. (Question 10) A YES response and/or BMI > 30 = ☐ HIGH RISK

Name: _____

Two or more checked HIGH RISK boxes indicate high likelihood of sleep apnea.

TAKE THIS INFORMATIONAL QUESTIONAIRE TO YOUR NEXT DOCTOR'S APPOINTMENT TO DISCUSS THE RESULTS

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