

Berlin questionnaire

Name _____

Address _____

SLEEP EVALUATION

1 Complete the following:

height _____ age _____

weight _____ male/female _____

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 wake time, do you feel tired, fatigued or not wake 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 a vehicle?

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

BMI = _____

Scoring Questions: Any answer within 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 or more positive responses and/or a BMI > 30

Final Results: 2 or more positive categories indicates a high likelihood of sleep disordered breathing.

EDWARD