

Berlin Sleep Questionnaire

Instructions: Complete evaluation & take it with you to your next doctor appointment

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 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 highlighted 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 categories indicate a high likelihood of sleep disordered breathing