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 time 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