

Berlin questionnaire

Name: _____

Please answer the following questions to your best ability and submit to your primary care physician:

<u>Category 1</u>	<u>Category 2</u>
1. Do you snore? <input type="checkbox"/> yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	6. How often do you feel tired or fatigued after your sleep? <input type="checkbox"/> Nearly every day <input type="checkbox"/> 3-4 times a week <input type="checkbox"/> 1-2 times a week <input type="checkbox"/> 1-2 times a month <input type="checkbox"/> Rarely if ever
If you Snore:	
2. Your Snoring is? <input type="checkbox"/> slightly louder than breathing <input type="checkbox"/> As loud as talking <input type="checkbox"/> louder than talking <input type="checkbox"/> Very loud. Can be heard in neighboring rooms.	7. During your wake time, do you feel tired, fatigued, or not as awake as you should be? <input type="checkbox"/> Nearly every day <input type="checkbox"/> 3-4 times a week <input type="checkbox"/> 1-2 times a week <input type="checkbox"/> 1-2 times a month <input type="checkbox"/> Rarely if ever
3. How often do you snore? <input type="checkbox"/> Nearly every day <input type="checkbox"/> 3-4 times a week <input type="checkbox"/> 1-2 times a week <input type="checkbox"/> 1-2 times a month <input type="checkbox"/> Rarely if ever	8. Have you ever nodded off or fallen asleep while driving a vehicle? <input type="checkbox"/> Yes <input type="checkbox"/> No
4. Has your snoring ever bothered other people? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, how often does it occur? <input type="checkbox"/> Nearly every day <input type="checkbox"/> 3-4 times a week <input type="checkbox"/> 1-2 times a week <input type="checkbox"/> 1-2 times a month <input type="checkbox"/> Rarely if ever
5. Has anyone noticed that you stop breathing when you are sleeping? <input type="checkbox"/> Nearly every day <input type="checkbox"/> 3-4 times a week <input type="checkbox"/> 1-2 times a week <input type="checkbox"/> 1-2 times a month <input type="checkbox"/> Rarely if ever	Category 3
	9. Do you have high blood pressure? <input type="checkbox"/> yes <input type="checkbox"/> No <input type="checkbox"/> Don't know

Tip for adding your score: Any check mark by a black highlighted answer is called a positive response.

Score your categories:

- | | |
|--------------------------|---|
| <input type="checkbox"/> | Check here when two or more responses within Category 1 are positive. |
| <input type="checkbox"/> | Check here when two or more responses within Category 2 are positive. |
| <input type="checkbox"/> | Check here when your response in Category 3 is positive. |

Final Result: If two or more categories are checked as positive, you have a high likelihood of having some form of sleep disordered breathing.

Shephard 03/09