

Berlin Questionnaire

Sleep Evaluation in Primary Care

Please Complete the following:

height _____ age _____
weight _____ male/female _____

Category 1

1. Do you snore?

- yes
 no
 don't know

If you snore:

2. Your snoring is?

- slightly louder than breathing
 as loud as talking
 louder than talking
 very loud. Can be heard in adjacent rooms.

3. 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

4. Has your snoring ever bothered other people?

- yes
 no

5. 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

6. 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

Category 2

7. During your waketime, do you feel tired, fatigued or not 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

8. 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

9. Do you have high blood pressure?

- yes
 no
 don't know

10. BMI > 30 (See Chart)

- yes
 no

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 1-5
 Category 2 is positive with 2 or more positive responses to questions 6-8
 Category 3 is positive with 1 positive responses to questions 9-10

Final Result: If 2 or more possible categories are positive, you have a high likelihood of sleep apnea.

Name _____

Address _____
