

# Berlin questionnaire

Name: \_\_\_\_\_

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

## 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 neighboring 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
- Rarely if ever

4. Has your snoring ever bothered other people?

- Yes
- No

5. Has anyone noticed that you stop breathing when you are sleeping?

- Nearly every day
- 3-4 times a week
- 1-2 times a week
- 1-2 times a month
- Rarely if ever

## Category 2

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
- Rarely if ever

7. During your wake time, do you feel tired, fatigued, or not as awake as you should be?

- Nearly every day
- 3-4 times a week
- 1-2 times a week
- 1-2 times a month
- Rarely if ever

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
- Rarely if ever

## Category 3

9. Do you have high blood pressure?

- yes
- No
- Don't know

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

Score your categories:

- Check here when two or more responses within Category 1 are positive.
- Check here when two or more responses within Category 2 are positive.
- 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.**