

## BERLIN QUESTIONNAIRE

### SLEEP EVALUATION

**1 Complete the following:**

Age \_\_\_\_\_ 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 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

**Height:** \_\_\_\_\_ **Weight:** \_\_\_\_\_