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

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
- ☐ never or nearly never

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 _____

_____