

Berlin Questionnaire

SLEEP EVALUATION IN PRIMARY CARE

1. Complete the following:

height _____ age _____

weight _____ male/female _____

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

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 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

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

10. Do you have high blood pressure?

yes

no

don't know

BMI = _____

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 2-6

Category 2 is positive with 2 or more positive responses to questions 7-9

Category 3 is positive with 1 positive response &/or a BMI > 30

Final Result: 2 or more possible categories indicates a high likelihood of sleep disordered breathing.

Name _____

Address _____
