PATIENT COPY

Berlin Questionnaire

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

Name _____

Address _____

_____