BERLIN QUESTIONNAIRE

PATIENT NAME: __________________________ DOB: ___________ DATE: __________

Height (in): _______ Weight (lb): __________ Age: ________ Gender: ____________________

CATEGORY 1:

1. Do you snore?
   - [ ] Yes
   - [ ] No
   - [ ] Don’t Know

2. How loud is your snoring?
   - [ ] My snoring is as loud as breathing
   - [ ] My snoring is as loud as talking
   - [ ] My snoring is louder than talking
   - [ ] My snoring is very loud

3. How frequently do you snore?
   - [ ] Almost every day
   - [ ] 3 – 4 times per week
   - [ ] 1 – 2 times per week
   - [ ] 1 – 2 times per month
   - [ ] Never or almost never

4. Does your snoring bother other People?
   - [ ] Yes
   - [ ] No
   - [ ] Don’t know

5. How often have your breathing pauses been noticed?
   - [ ] Almost every day
   - [ ] 3 – 4 times per week
   - [ ] 1 – 2 times per week
   - [ ] 1 – 2 times per month
   - [ ] Never or almost never

CATEGORY 2:

6. Are you tired after sleeping?
   - [ ] Almost every day
   - [ ] 3 – 4 times per week
   - [ ] 1 – 2 times per week
   - [ ] 1 – 2 times per month
   - [ ] Never or almost never

7. Are you tired during wake time?
   - [ ] Almost every day
   - [ ] 3 – 4 times per week
   - [ ] 1 – 2 times per week
   - [ ] 1 – 2 times per month
   - [ ] Never or almost never

8. How often do you nod off or fall asleep while driving?
   - [ ] Almost every day
   - [ ] 3 – 4 times per week
   - [ ] 1 – 2 times per week
   - [ ] 1 – 2 times per month
   - [ ] Never or almost never

CATEGORY 3:

9. Do you have high blood pressure?
   - [ ] Yes
   - [ ] No
   - [ ] Don’t know