## **Berlin Questionnaire**

## Sleep Evaluation in Primary Care

Final Result: If 2 or more possible categories are positive,

you have a high likelihood of sleep apnea.

| Please Complete the following:  | Accredited by the American Academy of Sleep Medicine         |
|---|--|
| height age  | 985.493.4759   |
| weight male/female  | C. Have aftern do you feel timed an fetigued aftern          |
|   | 6. How often do you feel tired or fatigued after your sleep? |
| 1. Do you snore?  | O D poorly every day   |
| yes   | ☐ 3-4 times a week ☐ 1-2 times a month                       |
| no  | □ 1-2 times a week   |
| □ don't know  | © □ 1-2 times a week   |
|   | never or nearly never  |
| If you snore:   | I hever of flearly flever                                    |
| 2. Your snoring is?   | 7. During your waketime, do you feel tired,                  |
| ☐ slightly louder than breathing  | fatigued or not up to par?                                   |
| □ as loud as talking  | nearly every day   |
| □ louder than talking   | □ 3-4 times a week   |
| □ very loud. Can be heard in adjacent rooms.  | ☐ 1-2 times a week   |
| ,   | ☐ 1-2 times a month  |
| 3. How often do you snore?  | never or nearly never  |
| □ nearly every day  | inever of ficulty fiever                                     |
| ☐ 3-4 times a week  | 8. Have you ever nodded off or fallen asleep                 |
| ☐ 1-2 times a week  | while driving a vehicle?                                     |
| ☐ 1-2 times a month   | <u> </u>   |
| ☐ never or nearly never   | □ yes  |
| a never of nearly never   | □ no   |
| 4. Has your snoring ever bothered other   | if yes, how often does it occur?                             |
| people?   | nearly every day   |
| □ yes   | □ 3-4 times a week   |
| no  | □ 1-2 times a week   |
| _   | ☐ 1-2 times a week   |
| 5. Has anyone noticed that you quit   | □ never or nearly never                                      |
| breathing during your sleep?  | inever of fleatry flever                                     |
| □ nearly every day  | 9. Do you have high blood pressure?                          |
| ☐ 3-4 times a week  | m  |
| ☐ 1-2 times a week  | Category  I dou,t know                                       |
| ☐ 1-2 times a month   | ີ don't know   |
| never or nearly never   | ate Modify 11000   |
|   | O .  |
| Scoring Questions: Any answer within box outline is a positiv   | ve response  |
| positiv   | Name   |
| Scoring categories:   |  |
| ☐ Category 1 is positive with 2 or more positive responses to q☐ Category 2 is positive with 2 or more positive responses to q☐ Category 3 is positive with 1 positive responses to questions | uestions 6-8 Address   |

THIBODAUX REGIONAL SLEEP DISORDERS CENTER