



# BERLIN QUESTIONNAIRE SLEEP EVALUATION

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 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

6. How often do you feel tired or fatigued after you 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 wake time, 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

9. Do you have high blood pressure?

- yes
- no
- don't know

## FOR OFFICE USE ONLY

Scoring Questions: Any answer within the box outline is a positive response

BMI =

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 response to #9 and/or a BMI>30

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

# THE EPWORTH SLEEPINESS SCALE

How likely are you to doze off or fall asleep in the following situations?

Check one in each row:	0-No chance of dozing	1-Slight chance of dozing	2-Moderate chance of dozing	3-High chance of dozing
Sitting and reading	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Watching TV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting inactive in a public place (e.g. a theatre or meeting)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
As a passenger in a car for an hour without a break	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lying down to rest in the afternoon when circumstances permit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting and talking to someone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting quietly after a lunch without alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In a car, while stopped for a few minutes in traffic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## SLEEP CENTER EVALUATION

Have you ever had an evaluation at a Sleep Center?    Y     N

If YES:

Sleep Center Name \_\_\_\_\_  
Sleep Center Location \_\_\_\_\_  
Sleep Study Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Sleep Center Name \_\_\_\_\_  
Sleep Center Location \_\_\_\_\_  
Sleep Study Date \_\_\_\_/\_\_\_\_/\_\_\_\_

### FOR OFFICE USE ONLY

Epworth Sleepiness Score: \_\_\_\_\_

The Sleep Study showed:     mild     obstructive sleep apnea (OSA)  
 moderate     upper airway resistance syndrome (UARS)  
 severe

The evaluation showed an RDI of \_\_\_\_\_ and/or an AHI of \_\_\_\_\_

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_  
Office Forms/Sleep Patient Questionnaire P.3

**LIST ANY MEDICATIONS/SUBSTANCES WHICH HAVE CAUSED YOU TO HAVE AN ALLERGIC REACTION:**

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**LIST ANY MEDICATIONS CURRENTLY BEING TAKEN (including over the counter medications, vitamins, and supplements) AND REASON FOR TAKING:**

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**MEDICAL HISTORY**

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|--|--|--|
| <input type="checkbox"/> <input type="checkbox"/> Adenoids removed                       | <input type="checkbox"/> <input type="checkbox"/> Hay fever  | <input type="checkbox"/> <input type="checkbox"/> Morning dry mouth                                |
| <input type="checkbox"/> <input type="checkbox"/> Tonsils removed                        | <input type="checkbox"/> <input type="checkbox"/> Heart disorder   | <input type="checkbox"/> <input type="checkbox"/> Muscle spasms or cramps                          |
| <input type="checkbox"/> <input type="checkbox"/> Anemia                                 | <input type="checkbox"/> <input type="checkbox"/> Heart murmur   | <input type="checkbox"/> <input type="checkbox"/> Muscular dystrophy                               |
| <input type="checkbox"/> <input type="checkbox"/> Arteriosclerosis                       | <input type="checkbox"/> <input type="checkbox"/> Heart pounding or beating irregularly during the night | <input type="checkbox"/> <input type="checkbox"/> Needing extra pillows to help breathing at night |
| <input type="checkbox"/> <input type="checkbox"/> Asthma                                 | <input type="checkbox"/> <input type="checkbox"/> Heart pacemaker  | <input type="checkbox"/> <input type="checkbox"/> Nervous system irritability                      |
| <input type="checkbox"/> <input type="checkbox"/> Autoimmune disorders                   | <input type="checkbox"/> <input type="checkbox"/> Heart palpitations                                     | <input type="checkbox"/> <input type="checkbox"/> Nighttime sweating                               |
| <input type="checkbox"/> <input type="checkbox"/> Bleeding easily                        | <input type="checkbox"/> <input type="checkbox"/> Heart valve replacement                                | <input type="checkbox"/> <input type="checkbox"/> Osteoarthritis                                   |
| <input type="checkbox"/> <input type="checkbox"/> Chronic sinus problems                 | <input type="checkbox"/> <input type="checkbox"/> Heartburn or a sour taste in the mouth at night        | <input type="checkbox"/> <input type="checkbox"/> Osteoporosis                                     |
| <input type="checkbox"/> <input type="checkbox"/> Chronic fatigue                        | <input type="checkbox"/> <input type="checkbox"/> Hepatitis  | <input type="checkbox"/> <input type="checkbox"/> Poor circulation                                 |
| <input type="checkbox"/> <input type="checkbox"/> Congestive heart failure               | <input type="checkbox"/> <input type="checkbox"/> High blood pressure                                    | <input type="checkbox"/> <input type="checkbox"/> Prior orthodontic treatment                      |
| <input type="checkbox"/> <input type="checkbox"/> Current pregnancy                      | <input type="checkbox"/> <input type="checkbox"/> Immune system disorder                                 | <input type="checkbox"/> <input type="checkbox"/> Recent excessive weight gain                     |
| <input type="checkbox"/> <input type="checkbox"/> Depression                             | <input type="checkbox"/> <input type="checkbox"/> Injury to face   | <input type="checkbox"/> <input type="checkbox"/> Rheumatic fever                                  |
| <input type="checkbox"/> <input type="checkbox"/> Diabetes                               | <input type="checkbox"/> <input type="checkbox"/> Injury to mouth  | <input type="checkbox"/> <input type="checkbox"/> Rheumatoid arthritis                             |
| <input type="checkbox"/> <input type="checkbox"/> Difficulty concentrating               | <input type="checkbox"/> <input type="checkbox"/> Injury to neck   | <input type="checkbox"/> <input type="checkbox"/> Shortness of breath                              |
| <input type="checkbox"/> <input type="checkbox"/> Dizziness                              | <input type="checkbox"/> <input type="checkbox"/> Injury to teeth  | <input type="checkbox"/> <input type="checkbox"/> Swollen, stiff, or painful joints                |
| <input type="checkbox"/> <input type="checkbox"/> Emphysema                              | <input type="checkbox"/> <input type="checkbox"/> Irregular heart beat                                   | <input type="checkbox"/> <input type="checkbox"/> TMJ disorder                                     |
| <input type="checkbox"/> <input type="checkbox"/> Epilepsy                               | <input type="checkbox"/> <input type="checkbox"/> Jaw joint surgery                                      | <input type="checkbox"/> <input type="checkbox"/> Thyroid problems                                 |
| <input type="checkbox"/> <input type="checkbox"/> Fibromyalgia                           | <input type="checkbox"/> <input type="checkbox"/> Low blood pressure                                     | <input type="checkbox"/> <input type="checkbox"/> Wisdom teeth extraction                          |
| <input type="checkbox"/> <input type="checkbox"/> Frequent cough                         | <input type="checkbox"/> <input type="checkbox"/> Memory loss  |  |
| <input type="checkbox"/> <input type="checkbox"/> Frequent sore throat                   | <input type="checkbox"/> <input type="checkbox"/> Migraines  |  |
| <input type="checkbox"/> <input type="checkbox"/> Gastroesophageal Reflux Disease (GERD) |  |  |
| <input type="checkbox"/> <input type="checkbox"/> Other medical/dental history _____     |  |  |

