



# Berlin Questionnaire Sleep Evaluation

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

(For office use)

Scoring Questions: Any answer within the 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 and/or a BMI > 30

(BMI = Body Mass Index)

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

Patient Signature \_\_\_\_\_

Date \_\_\_\_\_

Berlin

# 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 theater or a 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"/>

Total Score: \_\_\_\_\_




*(Add columns 0-3)*

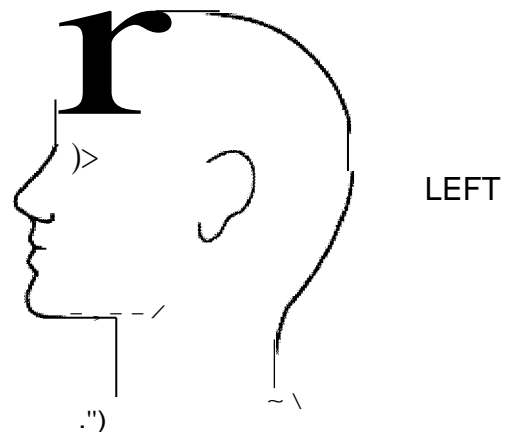
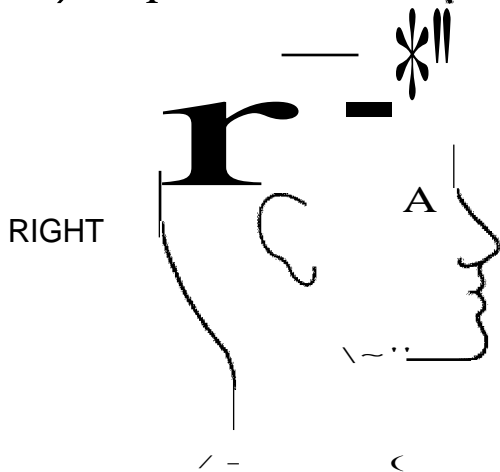
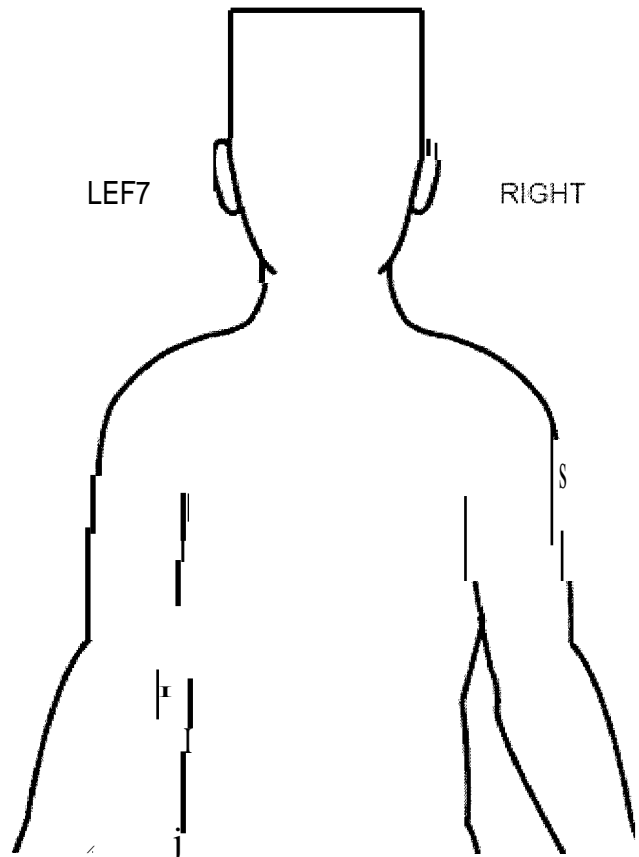
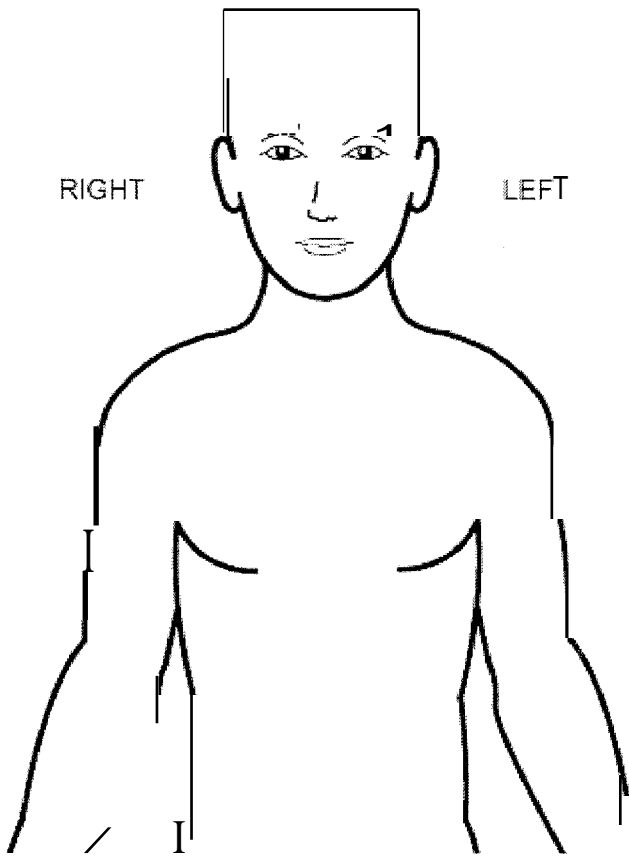
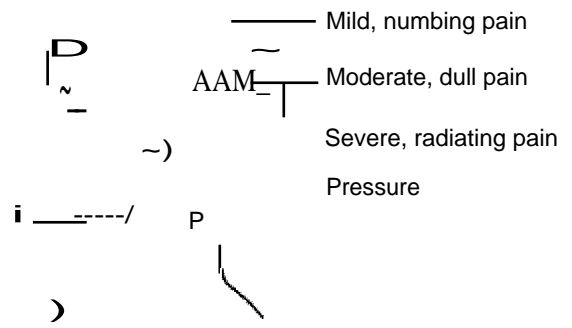
Patient Signature \_\_\_\_\_

Date \_\_\_\_\_

**DRAW YOUR PAIN PATTERNS FOLLOWING THIS KEY:**

EXAM PLE \_\_\_\_\_

- MILD PAIN  B Burning
- MODERATE PAIN  D Dull
- SEVERE PAIN  N Numbing
- P Pressure
- S Sharp
- T Tingling
- R Radiating



Patient Signature \_\_\_\_\_

Date \_\_\_\_\_

## List any medications which have caused an allergic reaction:

- Y  N Antibiotics  
 Y  N Aspirin  
 Y  N Barbiturates  
 Y  N Codeine  
 Y  N Iodine  
 Y  N Latex  
 Y  N Local anesthetics

- Y  N Metals  
 Y  N Penicillin  
 Y  N Plastic  
 Y  N Sedatives  
 Y  N Sleeping pills  
 Y  N Sulfa drugs

Other allergens:

---



---



---

## List any medications you are currently taking:

- Y  N Antacids  
 Y  N Antibiotics  
 Y  N Anticoagulants  
 Y  N Antidepressants  
 Y  N Anti-inflammatory drugs  
     (non-steroid)  
 Y  N Barbiturates  
 Y  N Blood thinners

- Y  N Codeine  
 Y  N Cortisone  
 Y  N Diet pills  
 Y  N Heart medication  
 Y  N High blood pressure medication  
 Y  N Insulin  
 Y  N Muscle relaxants  
 Y  N Nerve pills

- Y  N Pain medication  
 Y  N Sleeping pills  
 Y  N Sulfa drugs  
 Y  N Tranquilizers

Other current medications:

---



---



---

## Medical History

- Y  N Anemia  
 Y  N Arteriosclerosis  
 Y  N Asthma  
 Y  N Autoimmune disorders  
 Y  N Bleeding easily  
 Y  N Chronic sinus problems  
 Y  N Chronic fatigue  
 Y  N Congestive heart failure  
 Y  N Current pregnancy  
 Y  N Diabetes  
 Y  N Difficulty concentrating  
 Y  N Dizziness  
 Y  N Emphysema  
 Y  N Epilepsy  
 Y  N Fibromyalgia  
 Y  N Frequent sore throats  
 Y  N Gastroesophageal Reflux  
     Disease (GERD)  
 Y  N Hay fever  
 Y  N Heart disorder  
 Y  N Heart murmur  
 Y  N Heart pounding or beating  
     irregularly during the night

- Y  N Heart pacemaker  
 Y  N Heart valve replacement  
 Y  N Heartburn or a sour taste  
     in the mouth at night  
 Y  N Hepatitis  
 Y  N High blood pressure  
 Y  N Immune system disorder  
 Y  N Injury to  
      Face    Neck  
      Head    Mouth    Teeth  
 Y  N Insomnia  
 Y  N Irregular heart beat  
 Y  N Jaw joint surgery  
 Y  N Low blood pressure  
 Y  N Memory loss  
 Y  N Migraines  
 Y  N Morning dry mouth  
 Y  N Muscle spasms or  
     cramps  
 Y  N Needing extra pillows to  
     help breathing at night  
 Y  N Nighttime sweating

- Y  N Osteoarthritis  
 Y  N Osteoporosis  
 Y  N Poor circulation  
 Y  N Prior orthodontic treatment  
 Y  N Recent excessive weight  
     gain  
 Y  N Rheumatic fever  
 Y  N Shortness of breath  
 Y  N Swollen, stiff or painful  
     joints  
 Y  N Thyroid problems  
 Y  N Tonsillectomy (have had)  
 Y  N Wisdom teeth extraction

Other medical history:

---



---



---

Patient Signature \_\_\_\_\_

Date \_\_\_\_\_

# History of Present Illness

Have you been medically diagnosed with (check all that apply):

- Y  N  Migraine Headaches
- Y  N  Tension Headaches
- Y  N  Sleep Apnea

# Sleep Center Evaluation

Have you ever had an evaluation at a Sleep Center?  Yes  No

If Yes:

Sleep Center Name \_\_\_\_\_  
and Location \_\_\_\_\_

Sleep Study Date \_\_\_\_\_

### FOR OFFICE USE ONLY

The evaluation confirmed a diagnosis of:  *mild*  
 *moderate* obstructive sleep apnea  
 *severe*

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

# CPAP Intolerance (Continuous Positive Airway Pressure device)

If you have attempted treatment with a CPAP device, but could not tolerate it please fill in this section:

I could not tolerate the CPAP device due to:

- mask leaks
- I was unable to get the mask to fit properly
- discomfort caused by the straps and headgear
- disturbed or interrupted sleep caused by the presence of the device
- noise from the device disturbing my sleep and/or bed partner's sleep
- CPAP restricted movements during sleep
- CPAP does not seem to be effective
- pressure on the upper lip causing tooth related problems
- a latex allergy
- claustrophobic associations
- an unconscious need to remove the CPAP apparatus at night

Other: \_\_\_\_\_

# Other Therapy Attempts

What other therapies have you had for breathing disorders?  
(weight-loss attempts, smoking cessation for at least one month, surgeries, etc.)

---

---

---

Patient Signature \_\_\_\_\_

Date \_\_\_\_\_

