



SLEEP MANAGEMENT INSTITUTE

513.721.7533

800.441.7533

BERLIN QUESTIONNAIRE

NAME: _____

Height _____ Weight _____ Age _____ Male / Female

Please choose the correct response to each question.

CATEGORY 1

1. Do you snore?
 - a. Yes
 - b. No
 - c. Don't know

If you snore:

2. Your snoring is:
 - a. Slightly louder than breathing
 - b. As loud as talking
 - c. Louder than talking
 - d. Very loud - can be heard in adjacent room
3. How often do you snore?
 - a. Nearly every day
 - b. 3-4 times a week
 - c. 1-2 times a week
 - d. 1-2 times a month
 - e. Never or nearly never
4. Has your snoring ever bothered other people?
 - a. Yes
 - b. No
 - c. Don't know
5. Has anyone noticed that you quit breathing during your sleep?
 - a. Nearly every day
 - b. 3-4 times a week
 - c. 1-2 times a week
 - d. 1-2 times a month
 - e. Never or nearly never

CATEGORY 2

6. How often do you feel tired or fatigued after your sleep?
 - a. Nearly every day
 - b. 3-4 times a week
 - c. 1-2 times a week
 - d. 1-2 times a month
 - e. Never or nearly never
7. During your waking time, do you feel tired, fatigued or not up to par?
 - a. Nearly every day
 - b. 3-4 times a week
 - c. 1-2 times a week
 - d. 1-2 times a month
 - e. Never or nearly never
8. Have you ever nodded off or fallen asleep while driving a vehicle?
 - a. Yes
 - b. No

If Yes
9. How often does this occur?
 - a. Nearly every day
 - b. 3-4 times a week
 - c. 1-2 times a week
 - d. 1-2 times a month
 - e. Never or nearly never

CATEGORY 3

10. Do you have high blood pressure?
 - a. Yes
 - b. No
 - c. Don't know