

Berlin Questionnaire

Patient's Name: _____ DOB: _____ Male Female
Height (in): _____ Weight (lbs): _____ BMI: _____

1. Does patient snore?

- a. Yes (1 point)
- b. No
- c. Don't know

2. If yes, snoring is:

- a. slightly louder than breathing
- b. as loud as talking
- c. louder than talking (1 pt)
- d. very loud (1 pt)

3. How often does the patient snore?

- a. Nearly every day (1 pt)
- b. 3-4 times a week (1 pt)
- c. 1-2 times a week
- d. 1-2 times a month
- e. Never or nearly never

4. Has the snoring ever bothered other people?

- a. Yes (1 pt)
- b. No
- c. Don't know

5. Does patient stop breathing during sleep?

- a. Nearly every day (1 pt)
- b. 3-4 times a week (1 pt)
- c. 1-2 times a week
- d. 1-2 times a month
- e. Never or nearly never

Score: _____

Score higher than 2 indicates a positive.

Positive Negative

6. How often does patient feel tired after sleep?

- a. Nearly every day (1 pt)
- b. 3-4 times a week (1 pt)
- c. 1-2 times a week
- d. 1-2 times a month
- e. Never or nearly never

7. During waking time, does patient feel tired?

- a. Nearly every day (1 pt)
- b. 3-4 times a week (1 pt)
- c. 1-2 times a week
- d. 1-2 times a month
- e. Never or nearly never

8. Has patient ever nodded off or falling asleep while driving a vehicle?

- a. Yes (1 pt)
- b. No

Score: _____

Score higher than 2 indicates a positive.

Positive Negative

9. Does the patient have high blood pressure?

- a. Yes (1 pt)
- b. No
- c. Don't know

10. BMI: _____ (>30, add 1 point)

Score: _____

Score higher than 1 indicates a positive.

Positive Negative

- High risk: If 2 or more categories are marked positive. Consult Sleep Specialist.
- Low risk: If 1 or no categories are marked positive.