Berlin Questionnaire

Please choose the correct response to each question.

Category 1

1. Do you snore

◯ Yes ◯ No ◯ Not sure

1a. *If you snore, is your snoring:

◯ Slightly louder than breathing ◯ As loud as talking

◯ Louder thank talking ◯ Very loud - canbe heard in adjacent rooms

2. How often do you snore?

◯ Nearly every day ◯ 1 - 2 times a week ◯ 3 - 4 times a week

◯ 1 - 2 times a month ◯ Never or nearly never

3. Has your snoring ever bothered other people?

◯ Yes ◯ No ◯ Not sure

4. Has anyone noticed that you quit breathing during your sleep?

◯ Nearly every day ◯ 1 - 2 times a week ◯ 3 - 4 times a week

◯ 1 - 2 times a month ◯ Never or nearly never

Category 2

5. How often do you feel tired or fatigued after your sleep?

◯ Nearly every day ◯ 1 - 2 times a week ◯ 3 - 4 times a week

◯ 1 - 2 times a month ◯ Never or nearly never

6. During yor waking time do you feel tired, fatigued or not up to par?

- ◯ Nearly every day
- ◯ 1 - 2 times a week
- ◯ 3 - 4 times a week
- ◯ 1 - 2 times a month
- ◯ Never or nearly never

7. Have you ever nodded off or fallen asleep while driving a vehicle?

- ◯ Yes
- ◯ No

7a. *If yes, how often does this occur?

- ◯ Nearly every day
- ◯ 1 - 2 times a week
- ◯ 3 - 4 times a week
- ◯ 1 - 2 times a month
- ◯ Never or nearly never

Category 3

8. Do you have high blood pressure?

- ◯ Yes
- ◯ No
- ◯ Not sure

9. Height:

10. Weight:

Thornton Snoring Scale

Snoring has a significant effect on the quality of life for many people. Snoring can affect the person snoring and those around him/her, both physically and emotionally. Use the following scale to choose the most appropriate number for each situation. (Go to question #4 if you have no bed partner).
*rate each question before and after therapy
0 = Never
1 = Infrequently (1 night per week)
2 = Frequently (2-3 nights per week)
3 = Most of the time (4 or more nights per week)

1. My snoring affects my relationship with my partner

☐ 1 ☐ 2 ☐ 3

2. My snoring causes my partner to be irritable or tired

☐ 1 ☐ 2 ☐ 3

3. My snoring requires us to sleep in seperate rooms

☐ 1 ☐ 2 ☐ 3

4. My snoring is loud

☐ 1 ☐ 2 ☐ 3

5. My snoring affects people when I am sleeping away from home (i.e. hotel, camping, etc.)

☐ 1 ☐ 2 ☐ 3

OSA Sleep Disorder

Sleepiness/Fatigue

1. How would you describe yourself? (check all that apply)

☐ Fatigued ☐ Sleepy ☐ Tired ☐ Other

2. What tasks or activities have you eliminated or find difficulty in completing?

3. What is your energy level on a scale of 1-10?

◯ No energy ◯ 1 ◯ 2 ◯ 3 ◯ 4
◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9
◯ 10 ◯ Excellent

Sleep

1. Average time you go to sleep?

2. Average time you wake up?

3. Is it difficult to fall back asleep if youawake during the night?

◯ Yes ◯ No

4. How often do you awake during the night (bathroom, clock, noises, etc...)?

5. What is the quality of your sleep?

◯ Very poor	◯ 1	◯ 2	◯ 3	◯ 4
◯ 5	◯ 6	◯ 7	◯ 8	◯ 9
◯ 10	◯ Excellent			

Other symptoms (check all that apply)

☐ Allergies	☐ Impotence	☐ Sore throat	☐ Depression
☐ Recent weight gain	☐ Teeth grinding	☐ Headache	☐ Reflux

History

1. Have you ever been treated for your snoring or sleep disorder?

◯ Yes ◯ No

*If yes, by whom? Address and phone number (if known)

*If yes, what was the date of the evaluation?

*If yes, what was the diagnosis (if known)?

2. Describe any treatment that you may have received and the success and/or failure you experienced.

Sleep Disorder Breathing Examination Form

1. Change in weight- How is your weight compared to one year ago?

◯ Same as last year ◯ Gained ◯ Lost

2. Have you been treated for nasal congestion? (other than spring and fall allergies)

◯ Yes ◯ No

3. Neck Size

◯ Female less than 16" ◯ Female 16" or greater ◯ Males less than 17"
◯ Male 17" or greater

4. Alcohol consumption: How often do you consume alcohol within 2-3 hours of bedtime?

◯ Never ◯ Daily ◯ Once a week
◯ Several days a week

5. Do you take any type of sedatives before bedtime?

◯ Yes ◯ No

6. Sleep position - I prefer to sleep on my:

☐ Back ☐ Side ☐ Stomach ☐ No preference

7. Have you been told you stop breathing while you sleep?

◯ Yes ◯ No

8. Have you ever had surgery to correct your breathing problems?

◯ Yes ◯ No

*If yes, when and what procedure?

Response Date: