Sleep Laboratory

PULMONARY MEDICINE ASSOCIATES
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Berlin Questionnaire

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 from 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. Have 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 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

9. Have your ever nodded off or fallen asleep while driving a vehicle?
☐Yes
☐No

10. Do you have high blood pressure?
☐Yes
☐No
☐Don't know

Medicare mandated form

Name______________________

Date____________

DOB____________