

# Berlin Questionnaire

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## 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

**Southern California Sleep Disorders Specialists**

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