

# 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

Name \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_