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Sleep Apnea Syndrome Questionnaire (Berlin Questionnaire ©)

Last name:.....Name:.....Date of birth:.....
 Male Female

Please check the most appropriate answer.

<p>1. Do you snore?</p> <p><input type="checkbox"/> a. yes <input type="checkbox"/> b. no <input type="checkbox"/> c. Don't know</p> <p><i>if you checked yes:</i></p>	<p>6. How often do you feel tired or sleepy while getting up?</p> <p><input type="checkbox"/> a. almost every day <input type="checkbox"/> b. 3-4 times a week <input type="checkbox"/> c. 1-2 times a week <input type="checkbox"/> d. 1-2 times a month <input type="checkbox"/> e. not often or never</p>
<p>2. Is your snoring:</p> <p><input type="checkbox"/> a. a little louder than breathing <input type="checkbox"/> b. as loudly as speaking <input type="checkbox"/> c. louder than speaking <input type="checkbox"/> d. extremely loud, can be heard even through a closed door</p>	<p>7. How often do you feel tired or not fit during the day?</p> <p><input type="checkbox"/> a. almost every day <input type="checkbox"/> b. 3-4 times a week <input type="checkbox"/> c. 1-2 times a week <input type="checkbox"/> d. 1-2 times a month <input type="checkbox"/> e. not often or never</p>
<p>3. How often do you snore?</p> <p><input type="checkbox"/> a. almost every day <input type="checkbox"/> b. 3-4 times a week <input type="checkbox"/> c. 1-2 times a week <input type="checkbox"/> d. 1-2 times a month <input type="checkbox"/> e. not often or never</p>	<p>8. Have you ever fallen asleep at the wheel or dozed off?</p> <p><input type="checkbox"/> a. Yes <input type="checkbox"/> b. No</p> <p><i>if you checked yes:</i></p>
<p>4. Has your snoring ever disturbed other people?</p> <p><input type="checkbox"/> a. Yes <input type="checkbox"/> b. No <input type="checkbox"/> c. Don't know</p>	<p>9. How often did that happen?</p> <p><input type="checkbox"/> a. almost every day <input type="checkbox"/> b. times a week <input type="checkbox"/> c. 1-2 times a week <input type="checkbox"/> d. 1-2 times a month <input type="checkbox"/> e. not often or never</p>
<p>5. Has anyone observed pauses in your breathing during sleep?</p> <p><input type="checkbox"/> a. almost every day <input type="checkbox"/> b. 3-4 times a week <input type="checkbox"/> c. 1-2 times a week <input type="checkbox"/> d. 1-2 times a month <input type="checkbox"/> e. not often or never</p>	<p>10. Do you suffer from high blood pressure or do you take blood pressure medication?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know</p> <p>Weight:.....Height:.....BMI:.....</p>