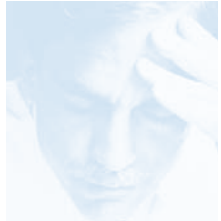


# Judy & Richard Voltmer Sleep Center

## Do you have sleep apnea?



Take the following Berlin Questionnaire<sup>®</sup> and learn more about the quality of your sleep.

If you think you may have a sleep disorder please discuss your concerns with your physician and/or contact Hoag Sleep Disorders Center at 949/764-8070.

Height (inches) \_\_\_\_\_  
Weight (lbs) \_\_\_\_\_  
Age \_\_\_\_\_  
Male / Female

Please choose the correct response to each question.

### Category 1

- Do you snore?
  - a. Yes
  - b. No
  - c. Don't Know

If you snore:

- Your snoring is?
  - a. Slightly louder than breathing
  - b. As loud as talking
  - c. Louder than talking
  - d. Very loud - can be heard in adjacent rooms
- How often do you snore?
  - a. Nearly every day
  - b. 3-4 times a week
  - c. 1-2 times a week
  - d. 1-2 times a month
  - e. Never or nearly never
- Has your snoring ever bothered other people?
  - a. Yes
  - b. No
  - c. Don't Know

- Has anyone noticed that you quit breathing during your sleep?
  - a. Nearly every day
  - b. 3-4 times a week
  - c. 1-2 times a week
  - d. 1-2 times a month
  - e. Never or nearly never

**Scoring - Category 1: items 1, 2, 3, 4, 5.**  
 Item 1: if 'Yes', assign **1 point**  
 Item 2: if 'c' or 'd' is the response, assign **1 point**  
 Item 3: if 'a' or 'b' is the response, assign **1 point**  
 Item 4: if 'a' is the response, assign **1 point**  
 Item 5: if 'a' or 'b' is the response, assign **2 points**

\_\_\_\_\_ **Total points**  
**Category 1 is positive if the total score is 2 or more points. Positive:**  Yes  No

### Category 2

- How often do you feel tired or fatigued after your sleep?
  - a. Nearly every day
  - b. 3-4 times a week
  - c. 1-2 times a week
  - d. 1-2 times a month
  - e. Never or nearly never
- During your waking time, do you feel tired, fatigued or not up to par?
  - a. Nearly every day
  - b. 3-4 times a week
  - c. 1-2 times a week
  - d. 1-2 times a month
  - e. Never or nearly never

- Have you ever nodded off or fallen asleep while driving a vehicle?
  - a. Yes
  - b. No

If yes:

- How often does this occur?
  - a. Nearly every day
  - b. 3-4 times a week
  - c. 1-2 times a week
  - d. 1-2 times a month
  - e. Never or nearly never

**Scoring - Category 2: items 6, 7, 8, (item 9 should be noted separately).**  
 Item 6: if 'a' or 'b' is the response, assign **1 point**  
 Item 7: if 'a' or 'b' is the response, assign **1 point**  
 Item 8: if 'a' is the response, assign **1 point**

\_\_\_\_\_ **Total points**  
**Category 2 is positive if the total score is 2 or more points. Positive:**  Yes  No

### Category 3

- Do you have high blood pressure?
  - a. Yes
  - b. No
  - c. Don't Know

**Scoring - Category 3 is positive if the answer to item 10 is 'Yes' OR if the BMI of the patient is greater than 30.**

$$BMI = \frac{\text{lbs} \times 703}{(\text{height in inches})^2}$$

**Positive:**  Yes  No

**High Risk:** if there are 2 or more Categories where the score is positive / **Low Risk:** if there is only 1 or no Categories where the score is positive