Modified Berlin Questionnaire

Name / Patient Number:

Height (m) _____ Weight (kg) _____ Age _____ Male / Female

***Please check the response that most correctly applies to you*:**

PART 1

1. **Have you been diagnosed with Sleep Apnea?**
   □ Yes □ No

   If No, stop here and move to Part 2.

2. **Do you use C-PAP?**
   □ Yes □ No

3. **How often do you use C-PAP?**
   □ Every night □ Every other night
   □ Twice a week □ Never

4. **Do you use any other device for treating Sleep Apnea (B-PAP, oral devices, etc)**
   □ Yes: □ No
   If Yes, which one? _____

5. **Do you use any medication for treating Sleep Apnea**
   □ Yes □ No

PART 2

Category 1

1. **Do you snore?**
   □ a. Yes
   □ b. No
   □ c. Don't know

   If you snore:

2. **Your snoring is:**
   □ a. Slightly louder than breathing
   □ b. As loud as talking
   □ c. Louder than talking
   □ Very loud – can be heard in adjacent rooms

3. **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

4. **Has your snoring ever bothered other people?**
   □ a. Yes
   □ b. No
   □ c. Don't know

5. **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

Category 2

6. **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

7. **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

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

   If Yes:

9. **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

Category 3

10. **Do you have high blood pressure?**
    □ a. Yes
    □ b. No
    □ c. Don't know

11. **BMI (kg/m^2) _____**