

Indiana Sleep Center

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BERLIN QUESTIONNAIRE

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 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 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 you 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 wake time, 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