BERLIN SLEEP QUESTIONNAIRE

ID NUMBER:									FORM CODE: BSQ VERSION: 1.0 10/26/10	Visit Number		SEQ #			

0a) Form Date ..... ☐☐/☐☐/☐☐☐☐ 0b) Initials ..... ☐☐☐

Instructions: *This form should be completed during the participant's visit. Please read questions exactly as written, and read all responses to the participant before recording an answer.*

This questionnaire assess breathing trouble while sleeping. I will read you all the response choices. Please select the best response for you for each question.

Category 1

1) Do you snore? ..... ☐

Yes ..... Y
No ..... N → **Go to 5**
Don't know ..... U → **Go to 5**

If you snore:

2) Your snoring is: ..... ☐

Slightly louder than breathing ..... A
As loud as talking ..... B
Louder than talking C
Very loud—can be heard in adjacent rooms ..... D

3) How often do you snore? ..... ☐

Nearly every day ..... A
3-4 times a week ..... B
1-2 times a week C
1-2 times a month ..... D
Never or nearly never ..... E

4) Has your snoring ever bothered other people? ..... ☐

Yes ..... Y
No ..... N
Don't know ..... U

The Berlin Questionnaire: Netzer NC. "Using the Berlin questionnaire to identify patients at risk for the sleep apnea syndrome. Ann. Int. Med; 131(7): 488 © American College of Physicians. October 5, 1999.

5) Has anyone noticed that you quit breathing during your sleep? ☐

Nearly every day ....A
3-4 times a week....B
1-2 times a week....C
1-2 times a month ....D
Never or nearly never....E

Category 2

6) How often do you feel tired or fatigued after your sleep? ☐

Nearly every day ....A
3-4 times a week....B
1-2 times a week....C
1-2 times a month ....D
Never or nearly never....E

7) During your waking time, do you feel tired, fatigued or not up to par? ☐

Nearly every day ....A
3-4 times a week....B
1-2 times a week....C
1-2 times a month ....D
Never or nearly never....E

8) Have you ever nodded off or fallen asleep while driving a vehicle? ☐

Yes....Y
No ....N → **Go to 10**

If yes:

9) How often does this occur? ☐

Nearly every day ....A
3-4 times a week....B
1-2 times a week....C
1-2 times a month ....D
Never or nearly never....E

Category 3

10) Do you have high blood pressure? ☐

Yes....Y
No ....N
Don't know....U

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