Sleep Center Evaluation

Have you ever had an evaluation at a Sleep Center? ☐ YES ☐ NO

If "YES":

Sleep Center Name: _____

Location: _____

Sleep Study Date: _____

FOR OFFICE USE ONLY

The evaluation confirmed a diagnosis of ☐ mild ☐ moderate ☐ severe obstructive sleep apnea

The evaluation showed an RDI of _____ and as AHI _____

Other Therapy Attempts

What other therapies have you had for breathing disorders?
(weight-loss attempts, smoking cessation for at least one month, surgeries, etc.)

_____

_____

_____

_____

Patient Signature: _____ Date: _____

Family History

1. Have any members of your family (blood kin) had

☐ YES	☐ NO	Heart disease
☐ YES	☐ NO	High blood pressure
☐ YES	☐ NO	Diabetes

2. Have any immediate family members been diagnosed or treated for a sleep disorder? ☐ YES ☐ NO

Social History

Alcohol consumption: How often do you consume alcohol within 2-3 hours of bedtime?

☐ Never ☐ Once a week ☐ Several days a week ☐ Daily ☐ Occasionally

Sedative consumption: How often do you take sedatives within 2-3 hours of bedtime?

☐ Never ☐ Once a week ☐ Several days a week ☐ Daily ☐ Occasionally

Caffeine consumption: How often do you consume caffeine 2-3 hours before bedtime?

☐ Never ☐ Once a week ☐ Several days a week ☐ Daily ☐ Occasionally

Do you smoke? ☐ YES ☐ NO

If yes, enter the number of packs per day (or other description of quantity)_____

Do you use chewing tobacco? ☐ YES ☐ NO

I authorize the release of a full report of examination findings, diagnosis, treatment programs, etc., to any referring or treating dentist or physician. I additionally authorize the release of any medical information to insurance companies or for legal documentation to process claims. I understand that I am responsible for all treatment regardless of insurance coverage.

Patient Signature _____ Date _____

Berlin Questionnaire Sleep Evaluation

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 times 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 that 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 waketime, do you feel tired, fatigued or not up to par?
- ☐ Neatly 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

(For office use)

Scoring Questions - Any answer within the box is a positive response

Scoring Categories
Category 1 is positive with 2 or more positive responses to questions 2-6 ☐
Category 2 is positive with 2 or more positive responses to questions 7-9 ☐
Category 3 is positive with 1 positive response and/or a BMI>30 ☐

BMI = Body Mass Index

Final Result 2 or more possible categories indicates a high likelihood of Sleep disordered breathing

Patient Signature _____ Date_____