

THE EPWORTH SLEEPINESS SCALE

How likely are you to doze off or fall asleep in the following situations?

✓ Check one in each row:	0 No chance of dozing	1 Slight chance of dozing	2 Moderate chance of dozing	3 High chance of dozing
Sitting and reading	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Watching TV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting inactive in a public place (e.g. a theater or a meeting)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
As a passenger in a car for an hour without a break	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lying down to rest in the afternoon when circumstances permit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting and talking to someone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting quietly after a lunch without alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In a car, while stopped for a few minutes in traffic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

<p>Total Score: _____</p> <p><i>(Add columns 0-3)</i></p>

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 your 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?

- 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

(For office use)

Scoring Questions: Any answer within the box outline 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 _____

Berlin

Sleep Center Evaluation

Have you ever had an evaluation at a Sleep Center? Yes No

If Yes:

Sleep Center Name _____
and Location _____

Sleep Study Date _____

FOR OFFICE USE ONLY

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

The evaluation showed an RDI of _____ and an AHI of _____

CPAP Intolerance (Continuous Positive Airway Pressure device)

If you have attempted treatment with a CPAP device, but could not tolerate it please fill in this section:

I could not tolerate the CPAP device due to:

- mask leaks
- I was unable to get the mask to fit properly
- discomfort caused by the straps and headgear
- disturbed or interrupted sleep caused by the presence of the device
- noise from the device disturbing my sleep and/or bed partner's sleep
- CPAP restricted movements during sleep
- CPAP does not seem to be effective
- pressure on the upper lip causing tooth related problems
- a latex allergy
- claustrophobic associations
- an unconscious need to remove the CPAP apparatus at night

Other: _____

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 _____

List any medications which have caused an allergic reaction:

- Y N Antibiotics
Y N Aspirin
Y N Barbiturates
Y N Codeine
Y N Iodine
Y N Latex
Y N Local anesthetics

- Y N Metals
Y N Penicillin
Y N Plastic
Y N Sedatives
Y N Sleeping pills
Y N Sulfa drugs

Other allergens:

List any medications you are currently taking:

- Y N Antacids
Y N Antibiotics
Y N Anticoagulants
Y N Antidepressants
Y N Anti-inflammatory drugs
(non-steroid)
Y N Barbiturates
Y N Blood thinners

- Y N Codeine
Y N Cortisone
Y N Diet pills
Y N Heart medication
Y N High blood pressure medication
Y N Insulin
Y N Muscle relaxants
Y N Nerve pills

- Y N Pain medication
Y N Sleeping pills
Y N Sulfa drugs
Y N Tranquilizers

Other current medications:

Medical History

- Y N Anemia
Y N Arteriosclerosis
Y N Asthma
Y N Autoimmune disorders
Y N Bleeding easily
Y N Chronic sinus problems
Y N Chronic fatigue
Y N Congestive heart failure
Y N Current pregnancy
Y N Diabetes
Y N Difficulty concentrating
Y N Dizziness
Y N Emphysema
Y N Epilepsy
Y N Fibromyalgia
Y N Frequent sore throats
Y N Gastroesophageal Reflux
Disease (GERD)
Y N Hay fever
Y N Heart disorder
Y N Heart murmur
Y N Heart pounding or beating
irregularly during the night

- Y N Heart pacemaker
Y N Heart valve replacement
Y N Heartburn or a sour taste
in the mouth at night
Y N Hepatitis
Y N High blood pressure
Y N Immune system disorder
Y N Injury to
 Face Neck
 Head Mouth Teeth
Y N Insomnia
Y N Irregular heart beat
Y N Jaw joint surgery
Y N Low blood pressure
Y N Memory loss
Y N Migraines
Y N Morning dry mouth
Y N Muscle spasms or
cramps
Y N Needing extra pillows to
help breathing at night
Y N Nighttime sweating

- Y N Osteoarthritis
Y N Osteoporosis
Y N Poor circulation
Y N Prior orthodontic treatment
Y N Recent excessive weight
gain
Y N Rheumatic fever
Y N Shortness of breath
Y N Swollen, stiff or painful
joints
Y N Thyroid problems
Y N Tonsillectomy (have had)
Y N Wisdom teeth extraction

Other medical history:

Patient Signature _____

Date _____

