Patient's name: **Date:** **Age:**

The Epworth Sleepiness Scale

Please use this scale to rate the likelihood of you DOZING or FALLING ASLEEP in the following situations, in contrast to just feeling tired. This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to estimate how they would have affected you.

	(0) Never	(1) Slight Chance	(2) Moderate Chance	(3) High Chance
Sitting and reading	O	O	O	O
Watching TV	O	O	O	O
Sitting inactive in a public place (i.e. movie or meeting)	O	O	O	O
As a passenger in a car for an hour without a break	O	O	O	O
Lying down to rest in the afternoon	O	O	O	O
Sitting and talking to someone	O	O	O	O
Sitting quietly after a lunch without alcohol	O	O	O	O
In a car, while stopped for a few minutes in traffic	O	O	O	O

Total Score: _________

The Berlin Questionnaire

Height (m) ________ **Weight (kg)**________ **Male / Female**

1. Do you snore?
O Yes
O No
O Don't know

2. *If you snore,* **your snoring is:**
O slightly louder than breathing
O as loud as talking
O louder than talking
O very loud (can be heard in adjacent room)

3. How often do you snore?
O nearly every day
O 3-4 times a week
O 1-2 times a week
O 1-2 times a month
O never or nearly never

4. Has your snoring ever bothered other people?
O Yes
O No
O Don't know

5. Has anyone noticed that you quit breathing during your sleep?
O nearly every day
O 3-4 times a week
O 1-2 times a week
O 1-2 times a month
O never or nearly never

6. How often do you feel tired or fatigued after your sleep?
O nearly every day
O 3-4 times a week
O 1-2 times a week
O 1-2 times a month
O never or nearly never

7. During your wake time, do you feel tired, fatigued, or not up to par?
O nearly every day
O 3-4 times a week
O 1-2 times a week
O 1-2 times a month
O never or nearly never

8. Have you ever nodded off or fallen asleep while driving a vehicle?
O Yes
O No
If yes, **how often does it occur?**
O nearly every day
O 3-4 times a week
O 1-2 times a week
O 1-2 times a month
O never or nearly never

9. Do you have high blood pressure?
O Yes
O No
O Don't know

BP______HR____ Date: _______________