Premier Dental Esthetics
"Creating Smiles to Last for Miles"
301 W. Huntington Dr., 217, Arcadia Ca 91007
626-445-2536; www.SmilesOfArcadia.com

Name:_____

Berlin Questionnaire Sleep Evaluation

1. Please complete the following:
Height_____ Weight_____ Neck Size:_____
Age_____ 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 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

For Office use:
Scoring Questions: Any answer in the box is a positive response.
- ○ Category 1 – is positive with 2 or more positive response to question 2-6
- ○ Category 2 is positive with 2 or more positive response to question 7-9
- ○ Category 3 is positive with 1 positive response and/or a BM! > 30

Final Result: 2 or more possible categories indicated a high likelihood of sleep disordered breath.

The Epworth Sleepiness Scale

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

Circle "0" no chance of dozing "1" Sight chance of dozing "2" Moderate chance of dozing "3" High chance of dozing

Sitting and reading	0	1	2	3
Watching TV	0	1	2	3
Sitting inactive in a public place (e.g. a theater or a meeting)	0	1	2	3
As a passenger in a car for an hour without a break	0	1	2	3
Lying down to rest in the afternoon when circumstances permit	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after a lunch without alcohol	0	1	2	3
In a car, while stopped for a few minutes in traffic	0	1	2	3

I have filled the above information to the best of my ability.

Patient's Signature_____Doctor's Signature_____Date_____

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Name:_____

Total Score:_____

Sleep/Snoring/Apnea History

PLEASE ANSWER YES OR NO TO THE FOLLOWING:	Yes	No
Have you been diagnosed by an physician of having sleep apnea/sleep disorder		
Do you become easily fatigue? At what time of day?		
Do you have problems with insomnia		
Do you sleep well? For How Long during most nights?		
Do you dream? How often?		
Do you have trouble falling asleep or staying asleep? Which?		
Do you snore or have you been told you do?		
Do you wake up with headaches?		
Have you had chronic sleepiness, fatigue or weariness that you can't explain?		
Have you fallen asleep during the day against your will?		
Have you had to pull off the road while driving due to sleepiness? (Exclude long distance driving)		
Have you been more irritable and short tempered?		
Have you felt that your memory and /or intellect is impaired?		
Have you been told that you stop breathing while asleep?		
About how many times per night do you wake up?		
What time do you normally go to bed? Get up in the morning?		
Of the hours you are in bed, about how many hours are you asleep?		
Would you rate the quality of your sleep as Good Fair Poor		
Do you have difficulty breathing through your nose?		
Have you been diagnosed or treated for a sleep disorder? When		
Have any immediate family members been diagnosed or treated for a sleep disorder?		
Have you even had an evaluation at a sleep center.		
Where and when did you have the sleep done?		
What professional advice or treatment have you receive about your snoring or sleep apnea?		
If you sought treatment for a sleep disorder, did it help?		

If you have not worn a CPAP Device, skip this section

Do you wear a CPAP device successfully during sleeping?					
How many hours per night do you wear your CPAP?					
Have you tried other therapies for your sleeping disorder?					
Please circle the other therapies: Weight Loss attempts		smoking cessation	surgeries	oral appliance	
Others:					
If you are not able to wear the CPAP, please circle the reasons below that pertains to the reasons why.					
Mask leaks,	Unfortunate mask,	unable to sleep well	noise of the pump		
Restricts movement	Straps not comfortable,	Pressure on the upper lips	Latex Allergy		
Claustrophobia	Others:				

If you have had a Sleep Study, please check one of the following.

Did you have a home sleep study?	Y	N
Did you go to a sleep center to have a polysomnographic evaluation done?	Y	N
Name of the Sleep Center:		
Date of the Sleep Study:		

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PERSONAL/FAMILY HISTORY

Do you have children? What are their ages?		
Does your partner help you?		
Do you have houseguest?		
Does your job satisfy you?		
Does your job require you to work at night?		
Are your biological parents still alive? What are their ages?		
If not, how did your parent/s passed away?		
At what age did they passed away?		

List of Physicians

PLEASE List all your physician you are seeing

MD's Name	**Specialty**	**Address, phone, email.**
	Primary Care Physician	
	Sleep Specialist	
	Neurologist	
	Ear-Nose-Throat Specialist	
	Internal Medicine Specialist	
	Endocrinologist	
	Others	
	Others	

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