



# 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"/>

Total Score: \_\_\_\_\_

(Add columns 0-3)

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

category 2  
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

category 3  
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.)

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Patient Signature \_\_\_\_\_

Date \_\_\_\_\_

