

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

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:

- | | | | | |
|--|-------------------|--|----------------|------------------|
| <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> | Antibiotics | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> | Metals | Other allergens: |
| <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> | Aspirin | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> | Penicillin | _____ |
| <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> | Barbiturates | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> | Plastic | _____ |
| <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> | Codeine | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> | Sedatives | _____ |
| <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> | Iodine | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> | Sleeping pills | _____ |
| <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> | Latex | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> | Sulfa drugs | _____ |
| <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> | Local anesthetics | | | |

List any medications you are currently taking:

- | | | | | | |
|--|--|--|--------------------------------|--|-----------------|
| <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> | Antacids | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> | Codeine | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> | Pain medication |
| <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> | Antibiotics | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> | Cortisone | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> | Sleeping pills |
| <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> | Anticoagulants | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> | Diet pills | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> | Sulfa drugs |
| <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> | Antidepressants | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> | Heart medication | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> | Tranquilizers |
| <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> | Anti-inflammatory drugs
(non-steroid) | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> | High blood pressure medication | | |
| <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> | Barbiturates | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> | Insulin | Other current medications: | _____ |
| <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> | Blood thinners | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> | Muscle relaxants | _____ | |
| | | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> | Nerve pills | _____ | |

Medical History

- | | | | | | |
|--|---|--|---|--|-------------------------------------|
| <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> | Anemia | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> | Heart pacemaker | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> | Osteoarthritis |
| <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> | Arteriosclerosis | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> | Heart valve replacement | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> | Osteoporosis |
| <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> | Asthma | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> | Heartburn or a sour taste
in the mouth at night | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> | Poor circulation |
| <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> | Autoimmune disorders | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> | Hepatitis | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> | Prior orthodontic treatment |
| <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> | Bleeding easily | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> | High blood pressure | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> | Recent excessive weight
gain |
| <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> | Chronic sinus problems | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> | Immune system disorder | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> | Rheumatic fever |
| <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> | Chronic fatigue | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> | Injury to | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> | Shortness of breath |
| <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> | Congestive heart failure | <input type="checkbox"/> | <input type="checkbox"/> Face <input type="checkbox"/> Neck | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> | Swollen, stiff or painful
joints |
| <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> | Current pregnancy | <input type="checkbox"/> | <input type="checkbox"/> Head <input type="checkbox"/> Mouth <input type="checkbox"/> Teeth | | |
| <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> | Diabetes | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> | Insomnia | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> | Thyroid problems |
| <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> | Difficulty concentrating | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> | Irregular heart beat | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> | Tonsillectomy (have had) |
| <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> | Dizziness | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> | Jaw joint surgery | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> | Wisdom teeth extraction |
| <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> | Emphysema | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> | Low blood pressure | Other medical history: | _____ |
| <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> | Epilepsy | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> | Memory loss | _____ | |
| <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> | Fibromyalgia | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> | Migraines | _____ | |
| <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> | Frequent sore throats | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> | Morning dry mouth | _____ | |
| <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> | Gastroesophageal Reflux
Disease (GERD) | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> | Muscle spasms or
cramps | _____ | |
| <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> | Hay fever | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> | Needing extra pillows to
help breathing at night | | |
| <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> | Heart disorder | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> | Nighttime sweating | | |
| <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> | Heart murmur | | | | |
| <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> | Heart pounding or beating
irregularly during the night | | | | |

Patient Signature _____

Date _____

