# Hoag Sleep Health Program

## Do you have sleep apnea?



Take the following Berlin Questionnaire© and learn more about the quality of your sleep.

If you think you may have a sleep disorder please discuss your concerns with your physician and/or contact Hoag Sleep Health Program at 949-764-8070.

Height (inches) _____
Weight (lbs) _____
Age _____
Male / Female

Please choose the correct response to each question.

### Category 1

1. Do you snore?
   - ☐ a. Yes
   - ☐ b. No
   - ☐ c. Don't Know

*If you snore:*

2. Your snoring is?
   - ☐ a. Slightly louder than breathing
   - ☐ b. As loud as talking
   - ☐ c. Louder than talking
   - ☐ d. Very loud - can be heard in adjacent rooms
3. How often do you snore?
   - ☐ a. Nearly every day
   - ☐ b. 3-4 times a week
   - ☐ c. 1-2 times a week
   - ☐ d. 1-2 times a month
   - ☐ e. Never or nearly never
4. Has your snoring ever bothered other people?
   - ☐ a. Yes
   - ☐ b. No
   - ☐ c. Don't Know
5. Has anyone noticed that you quit breathing during your sleep?
   - ☐ a. Nearly every day
   - ☐ b. 3-4 times a week
   - ☐ c. 1-2 times a week
   - ☐ d. 1-2 times a month
   - ☐ e. Never or nearly never

**Scoring – Category 1: items 1, 2, 3, 4, 5.**
Item 1: if **'Yes'**, assign **1 point**
Item 2: if **'c'** or **'d'** is the response, assign **1 point**
Item 3: if **'a'** or **'b'** is the response, assign **1 point**
Item 4: if **'a'** is the response, assign **1 point**
Item 5: if **'a'** or **'b'** is the response, assign **2 points**

_____ **Total points**
**Category 1 is positive if the total score is 2 or more points. Positive:** ☐ **Yes** ☐ **No**

### Category 2

6. How often do you feel tired or fatigued after your sleep?
   - ☐ a. Nearly every day
   - ☐ b. 3-4 times a week
   - ☐ c. 1-2 times a week
   - ☐ d. 1-2 times a month
   - ☐ e. Never or nearly never
7. During your waking time, do you feel tired, fatigued or not up to par?
   - ☐ a. Nearly every day
   - ☐ b. 3-4 times a week
   - ☐ c. 1-2 times a week
   - ☐ d. 1-2 times a month
   - ☐ e. Never or nearly never
8. Have you ever nodded off or fallen asleep while driving a vehicle?
   - ☐ a. Yes
   - ☐ b. No

*If yes:*

9. How often does this occur?
   - ☐ a. Nearly every day
   - ☐ b. 3-4 times a week
   - ☐ c. 1-2 times a week
   - ☐ d. 1-2 times a month
   - ☐ e. Never or nearly never

**Scoring – Category 2: items 6, 7, 8, (item 9 should be noted separately).**
Item 6: if **'a'** or **'b'** is the response, assign **1 point**
Item 7: if **'a'** or **'b'** is the response, assign **1 point**
Item 8: if **'a'** is the response, assign **1 point**

_____ **Total points**
**Category 2 is positive if the total score is 2 or more points. Positive:** ☐ **Yes** ☐ **No**

### Category 3

10. Do you have high blood pressure?
    - ☐ a. Yes
    - ☐ b. No
    - ☐ c. Don't Know

**Scoring – Category 3 is positive if the answer to item 10 is 'Yes' OR if the BMI of the patient is greater than 30.**

$$BMI = \frac{\text{lbs} \times 703}{(\text{height in inches})^2}$$

**Positive:** ☐ **Yes** ☐ **No**

***High Risk:*** *if there are 2 or more Categories where the score is positive /* ***Low Risk:*** *if there is only 1 or no Categories where the score is positive*


**Hoag Sleep Center Irvine**
(at Hoag Health Center Irvine - Sandy Canyon)
16305 Sand Canyon Avenue, Suite 230
Irvine, CA 92618
949-557-0130 | Fax: 949-557-0131

**Judy & Richard Voltmer Sleep Center**
(at Hoag Health Center Newport Beach)
510 Superior Avenue, Suite 280
Newport Beach, CA 92663
949-764-8070 | Fax: 949-650-4585

**www.hoag.org/sleep**

hoag Neurosciences Institute


4/17-LAD-XX-NN