# DEBORAH J. FREEHLING, M.D., INC.

*Board Certified*

**Ear Nose & Throat · Allergy · Head & Neck Surgery · Facial Plastic Surgery**

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## SNORING/SLEEP APNEA QUESTIONAIRE

**NAME:** _____ AGE: _____ SEX: _____ DATE: _____

HEIGHT: _____ WEIGHT: _____ WEIGHT ONE YEAR AGO: _____

1. DO YOU SNORE? YES_____ NO _____
   How long have you been snoring? _____
   How has your snoring been described? LOUD _____ SOFT _____ CONSTANT _____
   OTHER _____
   Do you snore on your back? _____ (R) side? _____ (L) side? _____

2. DO YOU MOUTHBREATHE DURING SLEEP? YES _____ NO ____ MAYBE ____
   AT TIMES _____

3. HAVE YOU BEEN TOLD THAT YOU STOP BREATHING (HAVE APNEA) DURING SLEEP?
YES _____ NO _____

4. DO YOU THINK YOU MIGHT HAVE APNEA DURING SLEEP? YES ____ NO ____
   MAYBE _____

5. DO YOU WAKE UP AT NIGHT? YES ____ NO _____
   How long have you been doing this? _____
   To urinate? _____
   How many times usually? _____
   For what other reasons? _____
   How many times usually? _____
   Does your heart beat quickly when you wake at night? _____

6. ARE YOU SLEEPY DURING THE DAY? YES _____ NO _____
   How long have you been feeling sleepy during the day? _____
   Do you take naps? _____
   How often? _____
   Do you fall asleep during the day? _____
   When? _____

7. WHAT TIME DO YOU USUALLY GO TO BED? _____

8. WHAT TIME DO YOU USUALLY WAKE UP? _____

9. WHAT TIME DO YOU USUALLY GET OUT OF BED? _____

10. WHAT PERCENTAGE OF THE TIME DO YOU FEEL REFRESHED OR TIRED IN THE
MORNING? _____

11. DO YOU DRINK CAFFEINATED BEVERAGES (COFFEE, TEA, COLA) UPON AWAKENING?
   YES _____ NO _____
   How many cups per day? _____

# EPWORTH SLEEPINESS SCALE

Please indicate the likelihood that you would fall asleep in the following situations (scale of 0-3). This refers to your usual way of life in recent times. Use the following scale to choose the *most appropriate number* for each situation:

0 = would ***never*** doze
1 = ***slight*** chance of dozing
2 = ***moderate*** chance of dozing
3 = ***high*** chance of dozing

| **Situation** | **Chance of dozing** |
|---|---|
| Sitting and reading | _____ |
| Watching TV | _____ |
| Sitting, inactive in a public place (e.g. a theater or a meeting) | _____ |
| As a passenger in a car for an hour without a break | _____ |
| Lying down to rest in the afternoon when circumstances permit | _____ |
| Sitting and talking to someone | _____ |
| Sitting quietly after a lunch without alcohol | _____ |
| In a car, while stopped for a few minutes in traffic | _____ |
| Total | |

**Thank you for your cooperation**

# Understanding the Diagnosis and Treatment of Obstructive Sleep Apnea

## Berlin Questionnaire

### Category 1

1. Do you snore?
2. How loud is your snoring?

   As loud as breathing
   As loud as talking
   Louder than talking
   Loud enough to be heard in the next room
3. How often do you snore?

   Nearly every day
   3-4 x /week
   1-2 x /week
   1-2 x /month
   Hardly ever
4. Has your snoring ever bothered other people?
5. Has anyone noticed you stop breathing when you are asleep?

   Nearly every day
   3-4 x /week
   1-2 x /week
   1-2 x /month
   Hardly ever

**Category 1 is positive if any of the above is present.**

### Category 2

1. After sleep, are you fatigued?

   3-4 x /week
   1-2 x /week
   1-2 x /month
   Hardly ever
2. While awake, are you fatiqued?

   3-4 x /week
   1-2 x /week
   1-2 x /month
   Hardly ever
3. Have you ever fallen asleep while driving a vehicle?

   Nearly every day
   3-4 x /week
   1-2 x /week
   1-2 x /month
   Hardly ever

**Category 2 is positive if any of the above is present.**

### Category 3

1. Do you have hypertension?
2. Is your BMI > 30?

**Category 3 is positive if any of the above is present.**

**If ≥ 2 categories are positive, high risk for sleep disorder.**