

Dataset name: berq_v1.3

Participant ID pid Acrostic acrostic
Interviewer compby Visit Code vc
Date of Visit vis_dat (mm/dd/yyyy)

Berlin Questionnaire (BQ)

CRF #1.3

Interviewer Note: Please have the participant choose the appropriate responses for each question. If the participant asks about the meaning of any question, re-read the statement (or questions) to them. Ask them to choose what seems to be the best option.

Pre-Interview Instructions to Participant:

“The following questions evaluate the risk of having sleep apnea, a breathing-related sleep disorder. Please choose the correct response to each question.”

Category 1

1. Do you snore? snore_berq

-9 -

1 Yes

2 No (Go to Q5)

3 Don't know (Go to Q5)

-6 Permanently Missing
2. Your snoring is: snorlv_berq

-9 -

1 Slightly louder than breathing

2 As loud as talking

3 Louder than talking

4 Very loud - can be heard in adjacent rooms

5 Don't know

-6 Permanently Missing
3. How often do you snore? snoroft_berq

-9 -

1 Nearly every day

2 3-4 times a week

3 1-2 times a week

4 1-2 times a month

5 Never or nearly never

6 Don't know

-6 Permanently Missing
4. Has your snoring ever bothered other people? bthppl_berq

-9 -

1 Yes

2 No

3 Don't know

-6 Permanently Missing
5. Has anyone noticed that you quit breathing during your sleep? qtbrrh_berq

-9 -

1 Nearly every day

2 3-4 times a week

3 1-2 times a week

4 1-2 times a month

5 Never or nearly never

6 Don't know

-6 Permanently Missing

-

Category 2

6. How often do you feel tired or fatigued after your sleep? tired_berq

-9 -

1 Nearly every day

2 3-4 times a week

3 1-2 times a week

4 1-2 times a month

5 Never or nearly never

-6 Permanently Missing

-

7. During your waking time, do you feel tired, fatigued or not up to par? wakfatgd_berq

-9 -

1 Nearly every day

2 3-4 times a week

3 1-2 times a week

4 1-2 times a month

5 Never or nearly never

-6 Permanently Missing

-

8. Have you ever nodded off or fallen asleep while driving a vehicle? spldrv_berq

-9 -

1 Yes

2 No (Go to Q10)

-6 Permanently Missing

-

9. How often does this occur? spldrvoft_berq

-9 -

1 Nearly every day

2 3-4 times a week

3 1-2 times a week

4 1-2 times a month

5 Never or nearly never

-6 Permanently Missing

-

Category 3

10. Do you have high blood pressure? hgbp_berq

-9 -

1 Yes

2 No

3 Don't know

-6 Permanently Missing

-

Source Form Language: lang

-9 -

1 English

2 Spanish

-

Participant ID (affix ID label here)	LIFE	Acrostic	<table border="1" style="width: 100%; height: 20px;"> <tr> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> </tr> </table>					
	Interviewer		<table border="1" style="width: 100%; height: 20px;"> <tr> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> </tr> </table>					
		Date of Visit	<table border="1" style="width: 100%; height: 20px;"> <tr> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> </tr> </table> <div style="display: flex; justify-content: space-around; font-size: small;"> month day year </div>					
			Visit Code					
			<table border="1" style="width: 100%; height: 20px;"> <tr> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> </tr> </table>					

Berlin Questionnaire (BQ)

Interviewer Note: Please have the participant choose the appropriate responses for each question. If the participant asks about the meaning of any question, re-read the statement (or questions) to them. Ask them to choose what seems to be the best option.

Pre-Interview Instructions to Participant:

“The following questions evaluate the risk of having sleep apnea, a breathing-related sleep disorder. Please choose the correct response to each question.”

Category 1	
1. Do you snore?	<div style="display: flex; justify-content: space-around;"> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know </div> <div style="display: flex; justify-content: space-around; margin-top: 5px;"> <div style="text-align: center;">↓ Go to Question 5</div> <div style="text-align: center;">↓ Go to Question 5</div> </div>
2. Your snoring is:	<input type="checkbox"/> Slightly louder than breathing <input type="checkbox"/> As loud as talking <input type="checkbox"/> Louder than talking <input type="checkbox"/> Very loud – can be heard in adjacent rooms <input type="checkbox"/> Don't Know
3. How often do you snore?	<input type="checkbox"/> Nearly every day <input type="checkbox"/> 3-4 times a week <input type="checkbox"/> 1-2 times a week <input type="checkbox"/> 1-2 times a month <input type="checkbox"/> Never or nearly never <input type="checkbox"/> Don't Know
4. Has your snoring ever bothered other people?	<div style="display: flex; justify-content: space-around;"> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know </div>
5. Has anyone noticed that you quit breathing during your sleep?	<input type="checkbox"/> Nearly every day <input type="checkbox"/> 3-4 times a week <input type="checkbox"/> 1-2 times a week <input type="checkbox"/> 1-2 times a month <input type="checkbox"/> Never or nearly never <input type="checkbox"/> Don't Know

Participant ID (affix ID label here)	<h1 style="margin: 0;">LIFE</h1>	Acrostic
		Visit Code

Category 2	
6. How often do you feel tired or fatigued after your sleep?	<input type="checkbox"/> Nearly every day <input type="checkbox"/> 3-4 times a week <input type="checkbox"/> 1-2 times a week <input type="checkbox"/> 1-2 times a month <input type="checkbox"/> Never or nearly never
7. During your waking time, do you feel tired, fatigued or not up to par?	<input type="checkbox"/> Nearly every day <input type="checkbox"/> 3-4 times a week <input type="checkbox"/> 1-2 times a week <input type="checkbox"/> 1-2 times a month <input type="checkbox"/> Never or nearly never
8. Have you ever nodded off or fallen asleep while driving a vehicle?	<input type="checkbox"/> Yes <input type="checkbox"/> No <div style="text-align: center;">↓ <i>Go to Question 10</i></div>
9. How often does this occur?	<input type="checkbox"/> Nearly every day <input type="checkbox"/> 3-4 times a week <input type="checkbox"/> 1-2 times a week <input type="checkbox"/> 1-2 times a month <input type="checkbox"/> Never or nearly never
Category 3	
10. Do you have high blood pressure?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know