EPWORTH SLEEPINESS SCALE

Name:_______________________________

DOB:_____________________

Today's Date:______________

In contrast to feeling tired, are you likely to doze or fall asleep in the following situations?

0 = Never
1 = Slight chance
2 = Moderate chance
3 = Regularly

Sitting quietly after lunch with no alcohol?
0 1 2 3
In a car while stopped for a few minutes in traffic?
0 1 2 3
Sitting inactive in a public place (e.g., a theater)?
0 1 2 3
As a passenger in a car for more than an hour without a break?
0 1 2 3
0 1 2 3
Watching television? Sitting and reading?
0 1 2 3
Lying down to rest in the afternoon?
0 1 2 3
Sitting and talking to someone?
0 1 2 3

Total of all numbers circled: ________________

APNEA/SNORING

Please circle any of your symptoms and how often they occur.

0 = Never
1 = Rarely
2 = Some of the time
3 = Frequently
4 = Most of the time

I have been told that I snore loudly even when I am sleeping on my side.
0 1 2 3 4
I have been told that I 'stop breathing' when sleeping.
0 1 2 3 4
I wake up in the morning with headaches.
0 1 2 3 4

Total of all numbers circled: _________________