

Name _____ Age _____ Sex _____ Date _____

THE EPWORTH SLEEPINESS SCALE

<p>How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life. Even if you have not done some of these things recently, try to work out how they would have affected you.</p> <p>Use the following scale to choose the most appropriate number for each situation:</p> <p>0 = would never doze 1 = slight chance of dozing 2 = moderate chance of dozing 3 = high chance of dozing</p>	<table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: left; padding-bottom: 5px;">Situation</th> <th style="width: 10%;"></th> </tr> </thead> <tbody> <tr> <td>Sitting and reading</td> <td style="text-align: right;">_____</td> </tr> <tr> <td>Watching TV</td> <td style="text-align: right;">_____</td> </tr> <tr> <td>Sitting inactive in a public place (e.g., theater or meeting)</td> <td style="text-align: right;">_____</td> </tr> <tr> <td>As a passenger in a car for an hour without a break</td> <td style="text-align: right;">_____</td> </tr> <tr> <td>Lying down to rest in the afternoon when circumstances permit</td> <td style="text-align: right;">_____</td> </tr> <tr> <td>Sitting and talking to someone</td> <td style="text-align: right;">_____</td> </tr> <tr> <td>Sitting quietly after lunch without alcohol</td> <td style="text-align: right;">_____</td> </tr> <tr> <td>In a car, while stopped for a few minutes in traffic</td> <td style="text-align: right;">_____</td> </tr> <tr> <td>TOTAL SCORE</td> <td style="text-align: right;">_____</td> </tr> </tbody> </table>	Situation		Sitting and reading	_____	Watching TV	_____	Sitting inactive in a public place (e.g., theater or 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 lunch without alcohol	_____	In a car, while stopped for a few minutes in traffic	_____	TOTAL SCORE	_____
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BEHAVIOR DURING SLEEP

<p>Use the following scale to choose the most appropriate number for each situation:</p> <p>0 = never during a usual night 1 = less than once a week 2 = once to about half the nights per week 3 = half the nights to almost always 4 = almost always or every night ? = don't know or haven't been told</p>	<p>During your usual sleep, you have noticed or been told you do the following:</p> <ol style="list-style-type: none"> 1. Snore loudly _____ 2. Stop breathing _____ 3. Choke, struggle for breath _____ 4. Toss and turn frequently _____ 5. Wake up with a headache _____ <p>Usual number of hours of sleep per night _____</p> <p>Number of times you rise to use toilet _____</p>
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Height ____ ft. _____ inches, present body weight _____ lbs., weight gained in last 12 mos. _____ lbs.

Have you had an overnight sleep test? _____

What other doctors have you seen about your snoring, and what did they advise or do?

Greater than a score of 7 Mild sleep apnea
 Greater than a score of 9 Moderate sleep apnea
 Greater than a score of 12 Severe sleep apnea

Signature _____