EPWORTH SLEEPINESS SCALE

(To be completed by patient)

PATIENT'S NAME: ________________________________

TODAY'S DATE: ________________________________

CHECK ONE: ______ MALE ______ FEMALE

DOB: ____________________

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 IN RECENT TIMES. EVEN IF YOU HAVE NOT DONE SOME OF THESE THINGS RECENTLY, TRY TO WORK OUT HOW THEY WOULD HAVE AFFECTED YOU. 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: (0-3)**
Sitting and reading	________
Watching TV	________
Sitting in a public place (e.g. Theatre/Meeting)	________
As a passenger in a car for an hour without a break	________
Lying down to rest in the afternoon when conditions present	________
Sitting and talking to someone	________
Sitting quietly after a lunch without alcohol	________
In a car, while stopped for a few minutes in traffic	________
Total:	________

____

PATIENT SIGNATURE