

## THE EPWORTH SLEEPINESS SCALE

Date: \_\_\_\_\_ Name: \_\_\_\_\_ D.O.B. \_\_\_\_\_ Age \_\_\_\_\_

This questionnaire measures your general level of daytime sleepiness. Be sure to review your responses with your healthcare professional. Regardless of the questionnaire results, if you have concerns, you are encouraged to discuss them with your healthcare professional.

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

<b>Situation</b>	<b>Chance of Dozing</b>
• Sitting and reading.....	_____
• Watching television.....	_____
• 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 Score: \_\_\_\_\_

Higher scores are associated with more daytime sleepiness. You should discuss your responses and your score with your healthcare professional. This questionnaire is not intended to make a diagnosis or take the place of talking with your healthcare professional.