THE EPWORTH SLEEPINESS SCALE

Name_____ DOB_____

Date_____ Age_____

Sex: M F

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your standard 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**
Sitting and reading	_____
Watching TV	_____
Sitting inactive in a public place, (e.g. 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 lunch without alcohol	_____
In a car, while stopped for a few minutes in traffic	_____
Total	_____/ 24

Has anyone ever told you that you quit breathing in your sleep? YES NO
If yes, who?

_____

_____

Does daytime fatigue interfere with your day to day life? YES NO
Explain:

_____

_____

_____

If your score is 10 or above and you answered yes to one or both of the questions, please consult your physician regarding a possible sleep disorder

Physicians: Please fax along with signed order to Wellnecessities (318)222-0883