SLEEP WELL MEDICAL CLINIC
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THE EPWORTH SLEEPINESS SCALE

Name:__________________________________Today's Date:__________________ Age:_________ Sex:_________

How likely are you to feel sleepy in the following situations; compared to just feeling 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 feel sleepy
1 = *slight* chance of being sleepy
2 = *moderate* chance of being sleepy
3 = *high* chance of being sleepy

SITUATION	**CHANCE OF DOZING**
Sitting and reading	________
Watching TV	________
Sitting inactive in a public place (meeting, theater)	________
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 eating lunch without alcohol	________
In a car while stopped for a few minutes in traffic	________
ESS Total Points	________

Additional Questions:

Do you snore severely?
□ a. Yes
□ b. No
□ c. Don't know

Do you have difficult-to-Control high blood pressure?
□ Yes □ No

Have you ever been told that you stop breathing during your sleep?
□ a. Yes
□ b. No
□ c. Don't know

Do you often (at least 3-4 Times a week) feel tired or fatigued?
□ a. Yes
□ b. No
□ c. Don't know

For patients undergoing Sleep Evaluation

Please complete the following questions:

Do you snore?	Yes	No	Sometimes
Been told that you stop breathing while asleep?	Yes	No	Sometimes
Do you wake up gasping or choking?	Yes	No	Sometimes
Experience bedtime aching/twitching in legs at bedtime?	Yes	No	Sometimes
Do you experience pain/discomfort during sleep?	Yes	No	Sometimes
Do headaches awaken you?	Yes	No	Sometimes
Are you anxious or have racing thoughts at bedtime?	Yes	No	Sometimes
Do others complain about your sleep?	Yes	No	Sometimes
Do you have to wake up to go to the bathroom?	Yes	No	Sometimes

Patient Name (Printed): ______________________________

Patient Signature: ______________________________ Date: ______________