The Epworth Sleepiness Scale

Name:_________________________________ Date:____________

Your age (years):________ Male ☐ Female ☐

How likely are you to doze off or fall asleep in the following situations, in contrast 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 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 (ie: 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 the traffic	________
TOTAL:	________

If you answered yes to 6 or more of these situations you have a HIGH possibility of suffering with sleep disordered breathing

1) Do you or any member of your family snore or have sleep apnea?

☐ YES ☐ NO

2) Have you or any member of your family had an over night sleep test at a hospital or independent sleep center?

☐ YES ☐ NO

3) Are you or they currently being treated for snoring or sleep apnea?

☐ YES ☐ NO

4) How are you or they being treated?

CPAP ☐ Surgery ☐
"Nasal" Continuous Positive Airway Pressure

Dental Oral Appliance ☐ Other ☐

Comments:____
____
____

5) Are you or they in compliance, meaning still using the treatment?

☐ YES ☐ NO

Comments:____
____
____