

EPWORTH SLEEPINESS SCALE



Patient's Name: _____

Under usual conditions, living as you do now, how likely are you to doze off or fall asleep in each of the following situations?

Even if you haven't done some of these things recently, try to imagine what chance you would have of dozing.

Use the following scale to check the box with the most appropriate number for each situation:

- 0 = No chance of dozing**
- 1 = Slight chance of dozing**
- 2 = Moderate chance of dozing**
- 3 = High chance of dozing**

SITUATION	CHANCE OF DOZING			
1. Sitting and reading	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
2. Watching Television.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
3. Sitting inactive in a public place.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
4. As a passenger in a car for an hour without a break.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
5. Lying down to rest in the afternoon.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
6. Sitting and talking to someone.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
7. Sitting quietly after a lunch without alcohol.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
8. In a car, while stopped for a few minutes in traffic.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3

PATIENT SIGNATURE: _____ DATE: _____

Epworth Sleepiness Score: _____

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