## **EPWORTH SCALE**

Date: \_\_\_\_\_

Patient Name:

| 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. Please check one box per line. If you are currently on CPAP, please answer how you PRESENTLY feel.  Chance of Dozing off: (PLEASE CHECK THE BOXES THAT BEST DESCRIBE YOU)  Never Slight Moderate High  O 1 2 3 Sitting and Reading  O 1 2 3 Watching TV  O 1 2 3 Sitting, active in a public place (meeting or theater)  O 1 2 3 Sitting, active in a public place (meeting or theater)  O 1 2 3 Sitting and talking to someone  O 1 2 3 Sitting quietly after lunch without alcohol  O 1 2 3 Sitting quietly after lunch without alcohol  O 1 2 3 Sitting quietly after lunch without alcohol  O 1 2 3 Sitting quietly after lunch without alcohol  O 1 2 3 In a car while stopped for a few minutes in traffic  Brief Sleep Symptom Checklist: (PLEASE CHECK THE BOXES THAT BEST DESCRIBE YOU)  Never Rarely Frequently Always    Sometimes of the predict of | How lil      | kely are you  | to DOZE off or t  | fall Asle | ep in the following situations, in contrast to feeling tired? This refers |  |
|--|--------------|---------------|-------------------|-----------|---|--|
| answer how you PRESENTLY feel.  Chance of Dozing off: (PLEASE CHECK THE BOXES THAT BEST DESCRIBE YOU)  Never Slight Moderate High 0 1 2 3 Sitting and Reading 0 1 2 3 Watching TV 0 1 2 3 Sitting, active in a public place (meeting or theater) 0 1 2 3 Sitting, active in a public place (meeting or theater) 0 1 2 3 Sitting down to rest in the afternoon when permitted 0 1 2 3 Sitting and talking to someone 0 1 2 3 Sitting and talking to someone 0 1 2 3 Sitting quietly after lunch without alcohol 0 1 2 3 Sitting quietly after lunch without alcohol 0 1 2 3 In a car while stopped for a few minutes in traffic  Brief Sleep Symptom Checklist: (PLEASE CHECK THE BOXES THAT BEST DESCRIBE YOU)  Never Rarely Frequently Always   | to you       | r usual way o | of life in recent | times. E  | ven if you have not done some of these things recently, try to work       |  |
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| Never Slight Moderate High  0 1 2 3 Sitting and Reading  0 1 2 3 Watching TV  0 1 2 3 Sitting, active in a public place (meeting or theater)  0 1 2 3 As a passenger in a car for an hour without a break  0 1 2 3 Lying down to rest in the afternoon when permitted  0 1 2 3 Sitting and talking to someone  0 1 2 3 Sitting and talking to someone  0 1 2 3 Sitting quietly after lunch without alcohol  0 1 2 3 In a car while stopped for a few minutes in traffic   Brief Sleep Symptom Checklist: (PLEASE CHECK THE BOXES THAT BEST DESCRIBE YOU)  Never Rarely Frequently Always   | answe        | r how you PF  | RESENTLY feel.    |           |   |  |
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| Weekdays: AM or PM Weekends: AM or PM What time do you wake up:  | •            |               |                   |           |   |  |
| What time do you wake up:  | What t       | ime do you g  | go to bed:        |           |   |  |
| ·  | Weekd        | ays:          | _AM or PM         |           | Weekends: AM or PM  |  |
| Weekdays: AM or PM Weekends: AM or PM  | What t       | ime do you v  | wake up:          |           |   |  |
|  |              |               |                   |           |   |  |
| Do you awaken refreshed?Yes or No  | <del>-</del> |               |                   |           |   |  |
| Do you nap? Yes or No How often do you nap? (times per week)   | -            |               |                   |           | ow often do you nap? (times per week)                                     |  |
| How long are the naps? minutes   |              | •             | • ———             |           |   |  |
| Are you a shift worker? Yes or No  |              |               |                   |           |   |  |
| If yes, what kind of shift do you work?  | -            |               | -                 |           |   |  |
| I have had a significant weight change since my last sleep study: Yes or No  |              |               |                   |           |   |  |
| I have been told that I kick my legs in my sleep: Yes or No  |              |               |                   |           |   |  |