EPWORTH SCALE

Patient Name: _____ Date: _____

How likely are you to DOZE off or fall Asleep in the following situations, in contrast to 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. 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	
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 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	
				I snore loudly
				I awaken gasping or choking for breath
				I have problems falling asleep or staying asleep (insomnia)
				My sleep is restless
				My sleep is disturbed by unusual behaviors: -Nightmares, Sleepwalking, Dream enhancements, Tongue biting, bedwetting, ETC
				I fall asleep while driving
				I have been told that I stop breathing in my sleep - Told by: _____

Sleep schedule (Please provide the following information)

What time do you go to bed:

Weekdays: _____ AM or PM Weekends: _____ AM or PM

What time do you wake up:

Weekdays: _____ AM or PM Weekends: _____ AM or PM

Do you awaken refreshed? _____Yes or No

Do you nap? _____ Yes or No How 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