

Feel free to print this and fill it out before coming in to our office. You might also wish to give a copy to that spouse who snores!

Patient Name: _____ **Date of Birth:** _____

EPWORTH SLEEPINESS SCALE

In contrast to just feeling tired, how likely are you to doze off or fall asleep in the following situations? 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 (i.e., in a theatre) _____

As a car passenger for an hour without a break _____

Lying down to rest in the afternoon _____

Sitting and talking to someone _____

Sitting quietly after lunch (without alcohol) _____

In a car, while stopping for a few minutes in traffic _____

TOTAL SCORE = _____

SLEEP OBSERVER SCALE

The following questions relate to the behavior that you have observed in the patient is while he/she is asleep. Use the following scale to choose the most appropriate number for each situation.

0=Never

1= Infrequently (1 night per week)

2= Frequently (2-3 nights per week)

3= Most of the time (4 or more nights per week)

- Loud, irritating snoring _____
- Choking or gasping for air _____
- Pauses in breathing _____
- Twitching / kicking of arms or legs _____
- Snoring requiring separate bedrooms _____
- Falling asleep inappropriately _____
(example: while driving or at meetings)

TOTAL SCORE = _____

A score of 5 or greater indicates symptoms which are affecting the health, safety, or quality of life of the observed person.

Have you had a sleep study? _____

Do you own a CPAP? _____ If so, do you use it nightly? _____

SIGNATURE: _____ DATE: _____