

THE EPWORTH SLEEPINESS SCALE

How likely are you to doze off or fall asleep in the following daytime situations, in contrast to just feeling tired? Even if you have not done some of these things recently, try to estimate the likelihood of dozing. Use the following scale to choose the most appropriate number for each situation:

0 = would never doze
2 = moderate chance of dozing

1 = slight chance of dozing
3 = high chance of dozing

Situation

Chance of Dozing

Never Slight Mod High

Sitting and reading	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Watching TV	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Sitting inactive, in a public place (e.g. a theater or meeting)	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
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
Lying down to rest in the afternoon when circumstances permit	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Sitting and talking to someone	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Sitting quietly after a lunch without alcohol	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
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

Total: _____

Name _____

Date _____

Height _____

Weight _____

BMI _____

Snoring? Yes No

Scale (0-10) _____