

Easy Screener Epworth Sleepiness Scale

Name: _____ DOB: _____
 Phone (Home): _____ Work: _____ Cell: _____
 Address: _____
 City, State, Zip: _____

The Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations? This refers to your usual way of life in recent times. Even if you have not done some things recently, try to work out how they would have affected you. Use the scale below to choose the most appropriate number for each situation. Write the numbers on each line and add them up on the total line.

Scale for chance of dozing: 0=never 1=slight 2=moderate 3=high

<u>Situation</u>	<u>Chance of dozing</u>
Sitting and reading _____	()
Watching television _____	()
Sitting inactive in a public place (ex: a theatre, meeting) _____	()
Sitting as a passenger in a car for an hour without a break _____	()
Lying down to rest in the afternoon when circumstances permit _____	()
Sitting and talking to someone _____	()
Sitting quietly after lunch without alcohol _____	()
Sitting in a car while stopped for a few minutes in traffic _____	()
Total Score: _____	

Please Circle One

Do you snore loudly or does it bother your bed partner?	YES	NO
Are you excessively tired or sleepy during the day?	YES	NO
Have you been told you stop breathing during sleep?	YES	NO
Do you wake during the night feeling breathless or gasping?	YES	NO
Do you wake feeling un-refreshed after a night's sleep?	YES	NO
Do you have a history of hypertension?	YES	NO
Male Gender or Menopausal Female?	YES	NO
Do you have trouble going to sleep or staying sleep?	YES	NO

Epworth Sleepiness Scale of 10 or greater or "yes" to four (or more) of the circled questions is a positive screen for sleep disordered breathing; you may want to discuss this with your physician.

Patient Signature: _____ Date: _____ Time: _____

If limited English proficient or hearing impaired, offer interpreter at no additional cost:

Interpreter Accepted _____ Interpreter Refused
 (Name/Number of Person/Services Chosen/Used)