## **Epworth Sleepiness Scale**

Patient Name	:					Date:		/	/	M or F
Height:	ft	in.	Weight:	lbs.	D.O.B.		/	/		Age:
		Pleas	se answer the	followir	ng questi	ons to	the be	st of you	ur abili	ty
Do you snore a  If yes, how won	_	rate the se	verity? Mild	d Mo	oderate	Sever	e	Yes	No	Occasionally
Have you been	told tha	t you have	e pauses in your	breathing v	while aslee	p?		Yes	No	Occasionally
Do you have difficulty falling asleep at the beginning of the night?							Yes	No	Occasionally	
Do you have d	ifficulty	staying as	sleep throughout	the night?				Yes	No	Occasionally
Do you experie	ence a re	stless sens	sation in your leg	gs while ly	ing in bed?	•		Yes	No	Occasionally
Have you been told that you make kicking and twitching movements while asleep?							Yes	No	Occasionally	
Do you feel drowsy when driving?						Yes	No	Occasionally		
Do you experie	ence exc	essive tire	dness during the	day?				Yes	No	Occasionally
Do you occasio	onally av	vaken feel	ling paralyzed?					Yes	No	Occasionally
Do you experie	ence sud	den loss o	f strength in you	r legs or ar	ms during	the day?		Yes	No	Occasionally

Yes

No

Occasionally

Do you experi	ence the	following:
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If yes, are these brought on by a sudden frightening event or laughter?

Dry Mouth Headaches Excessive Sweating Chocking or Gasping Nasal Congestion

Chest Pain Heart Burn

SITUATION	CHANCE OF DOZING						
Sitting and reading		0	1	2	3		
Vatching T.V.		0	1	2	3		
Sitting, inactive in a public place (i.e., movie theater)		0	1	2	3		
Lying down to rest in the afternoon when circumstances permit.		0	1	2	3		
As a passenger in a car for an hour without a break.		0	1	2	3		
Sitting and talking to someone.		0	1	2	3		
n a car, while stopped for a few minutes in traffic.		0	1	2	3		
Sitting quietly after lunch without alcohol $0 = \text{Would never doze}$ $1 = \text{Slight chance of dozing}$	0   1 2 = Moderate chance of dozing			2 3 3 = High chance of dozing			

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