EPWORTH SLEEPINESS SCALE

Daytime Sleepiness Evaluation

For the following situations, answer with one of the following numbers:

0 - would never doze *1 - slight chance of dozing* *2 - moderate chance of dozing* *3 - high chance of dozing*

Situation	Score
Sitting and reading	______
Watching Television	______
Sitting, inactive public place	______
As a passenger in a car for an hour without a break	______
Sitting and talking to someone	______
Sitting quietly after a lunch (no alcohol)	______
In a car, while stopped for a few minutes in traffic	______
Lying down to rest in the afternoon when circumstances permit	______
TOTAL SCORE:	______

Nighttime Sleepiness Evaluation

Developed by David White, M.D., Harvard Medical School, Boston, MA

Score

1. Snoring
   a. Do you snore on most nights (>3 nights per week)?
      Yes (2) No (0) ______
   b. Is your snoring loud? Can it be heard through a door or wall?
      Yes (2) No (0) ______
2. Has it ever been reported to you that you stop breathing or gasp during sleep?
   Never (0) Occasionally (3) Frequently (5) ______
3. What is your collar size?
   Male: Less than 17 inches (0) More than 17 inches (5)
   Female: Less than 16 inches (0) More than 16 inches (5) ______
4. Do you occasionally fall asleep during the day when:
   a. You are busy or active
      Yes (2) No (0) ______
   b. You are driving or stopped at a light?
      Yes (2) No (0) ______
5. Have you had or are you being treated for high blood pressure?
   Yes (2) No (0) ______

TOTAL SCORE: ______

I authorize the release of all examination findings and diagnosis, report and treatment plans, etc., to any referring or treating health care provider. I additionally authorize the release of any medical information to insurance companies, third party billing companies, or for legal documentation to process claims. I understand that I am responsible for all charges incurred for my treatment regardless of insurance coverage.

Patient/Parent Signature: ____ Date: ______________________