Millhon Clinic

OhioHealth

THE EPWORTH SLEEPINESS SCALE

Name: ________________________________ **Date of Birth:** ______________ **Today's Date:** ___________

How likely are you to doze off, or fall asleep in the following situations? (not feelings of tiredness) This refers to your usual way of life in recent times. 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	
Sitting and reading	___________
Watching TV	___________
Sitting, inactive in a public place (movies)	___________
As a passenger in a care for an hour without a break	___________
Lying down in the afternoon	___________
Sitting and talking to someone	___________
Sitting quietly after lunch (no alcohol)	___________
In a car while stopped for a few minutes	___________
TOTAL SCORE	___________

SLEEP QUESTIONAIRE

What time do you go to bed? ____

What time do you normally awake? ____

How many hours do you usually sleep? ____

How many hours do you sleep on the weekend? ____

Do you have trouble falling asleep?	☐ Yes ☐No
Do you awaken during the night to urinate? If so, how many times? ________________	☐ Yes ☐No
Do people complain about the loudness of your snoring?	☐ Yes ☐No
Has anyone noticed that you stop breathing during sleep?	☐ Yes ☐No
Do you awaken at night with choking or shortness of breath?	☐ Yes ☐No
Do you thrash around in bed at night?	☐ Yes ☐No
Do you have night sweats?	☐ Yes ☐No
Do you wake up in the mornings with a headache?	☐ Yes ☐No
Do you feel sleepy during the day even though you slept through the night?	☐ Yes ☐No
Do you feel refreshed after taking a nap?	☐ Yes ☐No
Do you have sleepiness which makes it difficult to work during the day?	☐ Yes ☐No

Do you notice sleepiness while driving?	☐ Yes ☐No
Have you fallen asleep while driving in the past 5 years?	☐ Yes ☐No
Do you ever have hallucinations or dreams while awake?	☐ Yes ☐No
Have you ever noticed that at times you are awake but unable to move?	☐ Yes ☐No
Have you ever dropped to the floor while awake?	☐ Yes ☐No
Do you legs feel unusual before you fall asleep? If so, please describe: ____ ____	☐ Yes ☐No
Questionnaire for spouse/partner/significant other	
Does the patient's snoring sound like sputtering, grunting or snorting?	☐ Yes ☐No
Do you notice the patient thrashing about in bed, trying to catch their breath?	☐ Yes ☐No
Do you notice if the patient stops breathing at night?	☐ Yes ☐No
Do you or have you considered sleeping in another room due to your spouse/partner or significant other's snoring?	☐ Yes ☐No

Questionnaire reviewed by (physician): ____ Date: ___________
(Print Name) (Signature)