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

<table>
<thead>
<tr>
<th>Situation</th>
<th>Chance of dozing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sitting and reading</td>
<td></td>
</tr>
<tr>
<td>Watching television</td>
<td></td>
</tr>
<tr>
<td>Sitting inactive in a public place (e.g. a theater, meeting)</td>
<td></td>
</tr>
<tr>
<td>Sitting as a passenger in a car for an hour without a break</td>
<td></td>
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<tr>
<td>Lying down to rest in the afternoon when circumstances permit</td>
<td></td>
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<tr>
<td>Sitting and talking to someone</td>
<td></td>
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<tr>
<td>Sitting quietly after lunch without alcohol</td>
<td></td>
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<tr>
<td>Sitting in a car while stopped for a few minutes in traffic</td>
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</tr>
<tr>
<td><strong>Total Score</strong></td>
<td></td>
</tr>
</tbody>
</table>

**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 up 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)
Physician Use Only

Physical Exam: circle one below

Class I
Class II
Class III
Class IV

BMI>30?: ☐ YES ☐ NO
Neck Circumference: _____ >17” Men _____ >16” Women

Heart/Lungs: ☐ Normal ☐ Abnormal

Co-Morbidities:

☐ HTN
☐ Cardiac Arrhythmias
☐ CVD

☐ CAD
☐ Diabetes Mellitus
☐ CHF

☐ Other
☐ Metabolic Syndrome
☐ Hyperlipidemia

☐ Referring Physician/Patient would like to arrange Consult/Comprehensive care by a sleep physician.

☐ Diagnostic Polysomnogram (PSG)

☐ Continuous Positive Airway Titratiom (CPAP and/or Bi-Level PAP as indicated)

☐ Multiple Sleep Latency Test (MSLT) (requires a sleep consult)

☐ Maintenance of Wakefulness Test (MWT) (requires a sleep consult)

Home Sleep Study

Patient Name: __________________________ DOB: __________________________

Phone Home: __________________________ Work: __________________________ Cell: __________________________

Physician Signature: __________________________ Dx: __________________________ Date: ______ Time: ______

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