

# Epworth Sleepiness Scale

Patient's name: \_\_\_\_\_ Date: \_\_\_\_\_

**How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired?**

This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you. Use the following scale to choose the MOST APPROPRIATE for each situation:

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

| Situation   | Chance of dozing |   |   |   |
|---|------------------|---|---|---|
|   | 0                | 1 | 2 | 3 |
| Sitting and reading   | 0                | 1 | 2 | 3 |
| Watching TV   | 0                | 1 | 2 | 3 |
| Sitting, inactive in a public place (e.g. theater or meeting) | 0                | 1 | 2 | 3 |
| As a passenger in a car for an hour without a break           | 0                | 1 | 2 | 3 |
| Lying down to rest in the afternoon when circumstances permit | 0                | 1 | 2 | 3 |
| Sitting and talking to someone                                | 0                | 1 | 2 | 3 |
| Sitting quietly after a lunch with alcohol                    | 0                | 1 | 2 | 3 |
| In a car, while stopped for a few minutes in traffic          | 0                | 1 | 2 | 3 |

## Bed-partner questionnaire

Name of person filling out this form: \_\_\_\_\_

I have observed this person's sleep:     Never     Once or twice     Often     Every night

Check any of the following behaviors that you have observed this person doing WHILE ASLEEP.

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Light snoring           | <input type="checkbox"/> Occasional loud snorts                 | <input type="checkbox"/> Crying out                  |
| <input type="checkbox"/> Loud snoring            | <input type="checkbox"/> Getting out of bed but not awake       | <input type="checkbox"/> Grinding teeth              |
| <input type="checkbox"/> Head rocking or banging | <input type="checkbox"/> Biting tongue                          | <input type="checkbox"/> Sleepwalking                |
| <input type="checkbox"/> Choking                 | <input type="checkbox"/> Twitching or kicking legs during sleep | <input type="checkbox"/> Sitting up in bed not awake |
| <input type="checkbox"/> Pauses in breathing     | <input type="checkbox"/> Twitching or kicking arms during sleep |  |
| <input type="checkbox"/> Other _____             |   |  |

Has this person ever fallen asleep during normal daytime activities or in dangerous situations?     Yes     No

Additional comments: \_\_\_\_\_

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**About falling asleep**

What time do you usually fall asleep? \_\_\_\_\_

What time do you try to get up? \_\_\_\_\_

Does this time vary? \_\_\_\_\_

How long does it take you to fall asleep? \_\_\_\_\_

On average, how many hours of sleep do you get each night? \_\_\_\_\_

When falling asleep or trying to fall asleep, how often do you:

| <i>Check ONE BOX for each statement</i>  | <b>Never</b>             | <b>Sometimes</b>         | <b>Often</b>             |
|--|--------------------------|--------------------------|--------------------------|
| Have thought racing through your mind?   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Have anxiety (worry about things)?   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Feel afraid of not being able to sleep?  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Feel unable to move?   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Have creeping, crawling, aching, or twitching feelings in your legs (feel like you have to move them)? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Have vivid, dream-like scenes even though you know you are not totally asleep?                         | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Have any kind of pain or discomfort?   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

How many times do you usually awaken each night? \_\_\_\_\_

Do you have trouble getting back to sleep?  Yes  No

How long have you had you sleep problem? \_\_\_\_\_

**About sleeping**

| <i>Check ONE BOX for each statement</i>              | <b>Never</b>             | <b>Sometimes</b>         | <b>Often</b>             |
|--|--------------------------|--------------------------|--------------------------|
| Feel afraid you won't return to sleep after awaking? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Sleep with someone else in your bed?                 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Have restless, disturbed sleep?                      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Snore loudly?  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Sweat a lot during the night?                        | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Walk in your sleep?                                  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Fall out of bed while asleep?                        | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Wake up screaming, violent, or confused?             | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Have unusual movements while asleep?                 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Grind your teeth at night?                           | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Are you a:  Sound sleeper  Restless sleeper

My sleep is frequently disturbed by: (*check ALL that are true*)

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Heat                                 | <input type="checkbox"/> Cough                           | <input type="checkbox"/> Need to urinate   |
| <input type="checkbox"/> Cold                                 | <input type="checkbox"/> Shortness of breath             | <input type="checkbox"/> Chest pain  |
| <input type="checkbox"/> Noise - household/outside            | <input type="checkbox"/> Pets/Children                   | <input type="checkbox"/> Frightening dreams  |
| <input type="checkbox"/> Noise or movement of your bedpartner | <input type="checkbox"/> Choking                         | <input type="checkbox"/> Creeping, crawling or aching feelings in your legs (like you have to move them) |
|   | <input type="checkbox"/> Indigestion, "gas" or heartburn |  |

**About waking up**

| How often do you:  | <i>Check ONE BOX for each statement</i> |                          |                          |
|--|---|--------------------------|--------------------------|
|  | <b>Never</b>                            | <b>Sometimes</b>         | <b>Often</b>             |
| Have a very hard time waking up?   | <input type="checkbox"/>                | <input type="checkbox"/> | <input type="checkbox"/> |
| Feel unable to move when waking up?  | <input type="checkbox"/>                | <input type="checkbox"/> | <input type="checkbox"/> |
| Have dream-like images when waking up even though you know you are not asleep? | <input type="checkbox"/>                | <input type="checkbox"/> | <input type="checkbox"/> |
| Wake up confused or disoriented?   | <input type="checkbox"/>                | <input type="checkbox"/> | <input type="checkbox"/> |
| Wake up with a headache?   | <input type="checkbox"/>                | <input type="checkbox"/> | <input type="checkbox"/> |
| Wake up sick to your stomach?  | <input type="checkbox"/>                | <input type="checkbox"/> | <input type="checkbox"/> |
| Wake up feeling rested?  | <input type="checkbox"/>                | <input type="checkbox"/> | <input type="checkbox"/> |
| Wake up 1 or 2 hours before you have to get up?                                | <input type="checkbox"/>                | <input type="checkbox"/> | <input type="checkbox"/> |

**About daytime functioning**

Do you take naps?  Yes  No If yes, are they refreshing?  Yes  No

How long do you usually sleep during a typical nap? \_\_\_\_\_

| How often do you:   | <i>Check ONE BOX for each statement</i> |                          |                          |
|---|---|--------------------------|--------------------------|
|   | <b>Never</b>                            | <b>Sometimes</b>         | <b>Often</b>             |
| Feel sleepy during the day?   | <input type="checkbox"/>                | <input type="checkbox"/> | <input type="checkbox"/> |
| Fall asleep unintentionally?<br>Please give an example:                       | <input type="checkbox"/>                | <input type="checkbox"/> | <input type="checkbox"/> |
| Feel sad or depressed?  | <input type="checkbox"/>                | <input type="checkbox"/> | <input type="checkbox"/> |
| Have anxiety? (worry about things)  | <input type="checkbox"/>                | <input type="checkbox"/> | <input type="checkbox"/> |
| Feel weakness in your muscles when laughing, surprised, angry, excited, etc.? | <input type="checkbox"/>                | <input type="checkbox"/> | <input type="checkbox"/> |

**Other questions**

Does anyone in your family have a sleep problem?  Yes  No

Relationship to you \_\_\_\_\_ Describe the problem \_\_\_\_\_

| How much fluids do you drink? | <b>During a typical day</b> | <b>Within 2 hours of bedtime</b> |
|-------------------------------|-----------------------------|----------------------------------|
| Coffee - Caffeinated          | _____ Cups                  | _____ Cups                       |
| Coffee - Decaffeinated        | _____ Cups                  | _____ Cups                       |
| Tea                           | _____ Cups                  | _____ Cups                       |
| Soda                          | _____ Cups                  | _____ Cups                       |
| Beer                          | _____ Cans                  | _____ Cans                       |
| Wine                          | _____ Glasses               | _____ Glasses                    |
| Other alcoholic beverages     | _____ Drinks                | _____ Drinks                     |

Do you smoke cigarettes??  Yes  No

How much tobacco do you smoke during a 24 hour period? \_\_\_\_\_

**Medication history**

Please list the name and dose (in mg.) of all medications you take NOW or WITHIN THE PAST 30 DAYS.

| <b>Medication</b> | <b>Dose</b> | <b>What for?</b> |
|-------------------|-------------|------------------|
| _____             | _____       | _____            |
| _____             | _____       | _____            |
| _____             | _____       | _____            |
| _____             | _____       | _____            |

Medication history continued >

|  |  |  |
|--|--|--|
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

Please list the name of any pill for sleeping or to help you stay awake that you have taken in the PAST

| Name | Did it help? |
|------|--------------|
|      |              |
|      |              |

**Health history**

Please check any problem or illness you have or have had:

- |  |                                       |  |   |  |
|--|---------------------------------------|--|---|--|
| <input type="checkbox"/> Heart disease     | <input type="checkbox"/> Asthma       | <input type="checkbox"/> High blood pressure     | <input type="checkbox"/> Bronchitis     | <input type="checkbox"/> Impotence       |
| <input type="checkbox"/> Headache          | <input type="checkbox"/> Cancer       | <input type="checkbox"/> Epilepsy                | <input type="checkbox"/> Allergies      | <input type="checkbox"/> Bladder trouble |
| <input type="checkbox"/> Black outs        | <input type="checkbox"/> Seizures     | <input type="checkbox"/> Prosthesis (Artificial) | <input type="checkbox"/> Kidney trouble | <input type="checkbox"/> Pneumonia       |
| <input type="checkbox"/> Dizziness         | <input type="checkbox"/> Incontinence | <input type="checkbox"/> Fainting                | <input type="checkbox"/> Heartburn      | <input type="checkbox"/> Ulcers          |
| <input type="checkbox"/> Stroke (Aneurysm) | <input type="checkbox"/> Depression   | <input type="checkbox"/> Hemophilia              | <input type="checkbox"/> Diabetes       | <input type="checkbox"/> Arthritis       |
| <input type="checkbox"/> Back trouble      | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Prostate trouble        | <input type="checkbox"/> Muscle cramps  |  |

Please list any hospitalizations and/or surgeries you have had. *List the most recent first.* \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please list any allergies you have: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Work routine**

How many hours a week do you work? \_\_\_\_\_

What are your usual work hours? From: \_\_\_\_\_ To: \_\_\_\_\_

Do you work different shifts now?  Yes  No If yes, describe: \_\_\_\_\_

Have you ever had a job which involved shift work?  Yes  No If yes, describe: \_\_\_\_\_

**Describe your sleep problems**

Use your own words to describe your sleep problems: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_