



Adult Epworth Sleepiness Scale

Patient Information

Patient Name: _____ Patient Last Name: _____ Preferred Name: _____ Date of Birth: _____ Gender: _____ Date: _____

How likely are you to doze off or fall asleep in the situations described below, in contrast to just feeling tired? Even if you have not done some of these things in the last month, try to imagine how they would have affected you. IT IS IMPORTANT THAT YOU ANSWER EACH QUESTION AS BEST AS YOU CAN.

Use the following scale to choose the most appropriate number for each situation: 0- NEVER doze 1- SLIGHT chance of dozing 2- MODERATE 3- HIGH chance of dozing

| | | | | | |
|--|--|--|---|---|------------------------------|
| Sitting & Reading | Watching TV | Sitting, inactive in a public place (eg. a theater or a meeting) | As a passenger in a car for an hour without a break | Lying down to rest in the afternoon when circumstances permit | Sitting & talking to someone |
| Siting quietly after a lunch without alcohol | In a car, while stopped for a few minutes in traffic | | Scale Total: | | |

I acknowledge I have answered to the best of my ability

Sign

Score Interpretation:

(1-10) Normal Range, (10-16) Excessively sleepy, (16-24) Abnormally sleepy