SLEEP DISORDERS QUESTIONNAIRE

Please answer all questions honestly so we may assess your level of sleepiness today.

Name:____ Date:____________________

Physician:____

THE EPWORTH SLEEPINESS SCALE

How likely are you to doze off or fall asleep in the following situations?

0 = would never doze/fall asleep
1 = slight chance of dozing/fall asleep
2 = moderate chance of dozing/fall asleep
3 =high chance of dozing/fall asleep

Circle the appropriate number

Situation	Chance of dozing
Sitting and reading	0 1 2 3
Watching TV	0 1 2 3
Sitting, inactive in a public place (e.g., a 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 lunch, without alcohol	0 1 2 3
In a car, while stopped for a few minutes in traffic while driving	0 1 2 3

Total Score from above:________

Other sleep related questions:

Do you often feel sleepy during the daytime? ☐**Yes** ☐**No**

Do you snore, or has anyone ever told you that you snore? ☐**Yes** ☐**No**

Has anyone ever told you that you stop breathing during sleep? ☐**Yes** ☐**No**

Do you ever have a choking or gasping sensation during sleep? ☐**Yes** ☐**No**

Do your legs 'kick' during sleep? ☐**Yes** ☐**No**