NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**THE EPWORTH SLEEPINESS SCALE (ESS)²**

The ESS is a simple survey that your patients can take to measure their general level of sleepiness. It has 8 routine daytime situations that they can rate on a scale from 0-3, based on their likelihood of dozing off or falling asleep in each situation. A total score of 10 or more on the ess suggests the need for further evaluation.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **SITUATION** | **WOULD NEVER DOZE** | **SLIGHT CHANCE OF DOZING** | **MODERATE**  **CHANCE OF DOZING** | **HIGH CHANCE**  **OF DOZING** | **SCORE** |
| SITTING & READING | **0** | **1** | **2** | **3** |  |
| WATCHING TELEVISION | **0** | **1** | **2** | **3** |  |
| SITTING INACTIVE IN A PUBLIC PLACE  EXAMPLE: IN A THEATER OR MEETING | **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 WITHOUT ALCOHOL | **0** | **1** | **2** | **3** |  |
| IN A CAR, WHILE STOPPED FOR A FEW MINUTES IN TRAFFIC | **0** | **1** | **2** | **3** |  |
| AS A PASSENGER IN A CAR FOR AN HOUR WITHOUT A BREAK | **0** | **1** | **2** | **3** |  |

**TOTAL:**

PLEASE CHECK OR FILL IN THE CIRCLE THAT BEST CORRESPONDS TO YOU

**FREQUENCY 0-1 TIMES/WEEK 1-2 TIMES/WEEK 3-4 TIMES/WEEK 5-7 TIMES/WEEK**

1.On Average in the past month, how often have you snored or been told you snore?

**NEVER⚪ RARELY⚪ SOMETIMES⚪ FREQUENTLY⚪ ALMOST ALWAYS⚪**

2**.**DO YOU WAKE UP CHOKING OR GASPING?

**NEVER⚪ RARELY⚪ SOMETIMES⚪ FREQUENTLY⚪ ALMOST ALWAYS⚪**

**3.**HAVE YOU BEEN TOLD THAT YOU STOP BREATHING IN YOUR SLEEP?

**NEVER⚪ RARELY⚪ SOMETIMES⚪ FREQUENTLY⚪ ALMOST ALWAYS⚪**

4.DO YOU HAVE PROBLEMS KEEPING YOUR LEGS STILL AT NIGHT OR NEED TO MOVE THEM TO FEEL COMFORTABLE?

**NEVER⚪ RARELY⚪ SOMETIMES⚪ FREQUENTLY⚪ ALMOST ALWAYS⚪**

|  |  |  |  |
| --- | --- | --- | --- |
|  | **NO** | **YES** | **FOR HOW LONG** |
| DO YOU WAKE WITH DRY MOUTH? |  |  |  |
| DO YOU HAVE HALLUCINATIONS? |  |  |  |
| DO YOU HAVE LOSS OF MEMORY? |  |  |  |