EPWORTH SLEEPINESS SCALE

PATIENT'S NAME: _____

TODAY'S DATE: _____

YOUR AGE: _____ SEX: ☐ Male ☐ Female

How likely are you to doze off or fall asleep in the situations described below, in contrast to just feeling tired? **This refers to your usual way of life in recent times.**

Even if you haven't done some of these things recently, please try to indicate how they **might** have affected you. Use the following scale to choose the **most appropriate number** for each situation:

0 = you would **never** doze off
1 = there is a **slight** chance of you dozing off
2 = there is a **moderate** chance of you dozing off
3 = there is a **high** chance of you dozing off

Situation	Chance of You Dozing Off
Sitting and reading	_____
Watching TV	_____
Sitting, inactive, in a public place (such as a theatre, a meeting, etc.)	_____
As a passenger in a car for one hour without a break	_____
Lying down to rest in the afternoon when circumstances permit	_____
Sitting and talking to someone	_____
Sitting quietly after a lunch without alcohol	_____
In a car, while stopped for a few minutes in traffic	_____
YOUR TOTAL:	_____

Score:

0 to 10	Normal range
10 to 12	Borderline
12 to 24	Abnormal range

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