HYDE PARK CENTER FOR
Sleep Disorders

EPWORTH SLEEPINESS SCALE FORM

Instructions: Be as truthful as possible. Print the form. Read the situation in the first column; select your response from the second column; enter that number in the third column. Total all of the entries in the third column and enter the total in the last box.

Situation	Responses	Score
Sitting and Reading	0 = would never doze 1 = slight chance of dozing 2 = moderate chance of dozing 3 = high chance of dozing	
Watching Television	0 = would never doze 1 = slight chance of dozing 2 = moderate chance of dozing 3 = high chance of dozing	
Sitting inactive in a public place, for example, a theater or a meeting	0 = would never doze 1 = slight chance of dozing 2 = moderate chance of dozing 3 = high chance of dozing	
As a passenger in a car for an hour without a break	0 = would never doze 1 = slight chance of dozing 2 = moderate chance of dozing 3 = high chance of dozing	
Lying down to rest in the afternoon	0 = would never doze 1 = slight chance of dozing 2 = moderate chance of dozing 3 = high chance of dozing	
Sitting and talking to someone	0 = would never doze 1 = slight chance of dozing 2 = moderate chance of dozing 3 = high chance of dozing	
Sitting quietly after lunch when you've had no alcohol	0 = would never doze 1 = slight chance of dozing 2 = moderate chance of dozing 3 = high chance of dozing	
In a car while stopped in traffic	0 = would never doze 1 = slight chance of dozing 2 = moderate chance of dozing 3 = high chance of dozing	
TOTAL SCORE		

A score of 10 or greater indicates a possible sleep disorder. Take the completed form to your doctor.

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Weekdays
Usual bedtime: _____ am/pm Usual awakening time: _____ am/pm

Weekends
Usual bedtime: _____ am/pm Usual awakening time: _____ am/pm

On average how many times do you awaken during the night? _____

If you have a bed partner, have they noticed you doing any of the following during your sleep? (circle)

Stop breathing Snore Have gasping arousals Talking

Jerk your legs Walking Grind your teeth Thrash around

Other: _____

Do you suffer from any of the following? (circle)

Excessive daytime sleepiness Difficulty initiating sleep Difficulty maintaining sleep

Frequent nocturnal awakenings Gasping arousals from your sleep Leg cramps (charlie horses

Nasal congestion Mouth breathing Heart Burn

Restless legs at sleep onset (discomfort in your limbs that make you need to move around)

Attacks of sudden, brief losses of muscle strength (cataplexy)

Vivid dream-like scenes when drowsy (hypnagogic hallucinations)

Paralysis just prior to falling asleep or upon awakening (sleep paralysis)

Awake from sleep screaming, violent, and confused (night terrors)

How many times have you ever been involved in automobile accidents, or near accidents, because of sleepiness? _____ times

How many daytime naps do you take? _____

Average total time napping during the day _____ minutes/hours

Is there anything else not covered by this questionnaire regarding your sleeping or waking problem tha you would like us to know? _____

_____

_____

_____ _____

Signature Date