EPWORTH SLEEPINESS SCALE
(Excessive Daytime Sleepiness)

COSTRINI SLEEP SERVICES
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Good Sleep, Good Life

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Name _____ Date _____

Date of Birth ___/___/___

How likely are you to doze off or fall asleep in the following situations, in contrast to just "feeling tired"? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to think about how they would affect you.

PLEASE COMPLETE THIS BASED ON HOW YOU CURRENTLY FEEL, NOT ON HOW YOU'VE FELT IN THE PAST OR HOW YOU WOULD FEEL WITHOUT TAKING YOUR MEDICINE OR USING YOUR CPAP.

USE THE FOLLOWING SCALE TO CHOOSE THE MOST APPROPRIATE NUMBER FOR EACH SITUATION.

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

Situation	*Chance of Dozing*
1. Sitting and reading……..	_____
2. Watching TV…….	_____
3. Sitting inactive in a public place (theater, meeting, etc.)……..	_____
4. As a passenger in a car for an hour without a break……	_____
5. Lying down to rest in the afternoon……..	_____
6. Sitting and talking to someone……..	_____
7. Sitting quietly after lunch without alcohol……	_____
8. In a car, while stopped for a few minutes in traffic……	_____
TOTAL SCORE……	_____

If your total score is 10 or higher, you are probably sleepier than you should be. You should share this information with your primary care physician.