Epworth Sleepiness Scale

Patient's name: ______________________________ Date: ______________

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 thing recently, try to work out how they would have affected you. Use the following scale to chose the MOST APPROPRIATE 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			
Sitting and reading	0	1	2	3
Watching TV	0	1	2	3
Sitting, inactive in a public place (e.g. 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 a lunch with alcohol	0	1	2	3
In a car, while stopped for a few minutes in traffic	0	1	2	3

Bed-partner questionnaire

Name of person filling out this form: ______________________________

I have observed this person's sleep: ☐ Never ☐ Once or twice ☐ Often ☐ Every night

Check any of the following behaviors that you have observed this person doing WHILE ASLEEP.

- ☐ Light snoring
- ☐ Loud snoring
- ☐ Head rocking or banging
- ☐ Choking
- ☐ Pauses in breathing
- ☐ Other ______________________________
- ☐ Occasional loud snorts
- ☐ Getting out of bed but not awake
- ☐ Biting tongue
- ☐ Twitching or kicking legs during sleep
- ☐ Twitching or kicking arms during sleep
- ☐ Crying out
- ☐ Grinding teeth
- ☐ Sleepwalking
- ☐ Sitting up in bed not awake

Has this person ever fallen asleep during normal daytime activities or in dangerous situations? ☐ Yes ☐ No

Additional comments:______________________________

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Continued >

Graymark Healthcare is committed to partnering with patients and physicians to promote and provide excellence in sleep medicine.

For information on sleep apnea or sleep testing clinics, visit: **www.graymarkhealthcare.com**

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About falling asleep

What time do you usually fall asleep? ______________________________

What time do you try to get up? ______________________________

Does this time vary? ______________________________

How long does it take you to fall asleep? ______________________________

On average, how many hours of sleep do you get each night? ______________________________

When falling asleep or trying to fall asleep, how often do you:

Check ONE BOX for each statement	**Never**	**Sometimes**	**Often**
Have thought racing through your mind?	☐	☐	☐
Have anxiety (worry about things)?	☐	☐	☐
Feel afraid of not being able to sleep?	☐	☐	☐
Feel unable to move?	☐	☐	☐
Have creeping, crawling, aching, or twitching feelings in your legs (feel like you have to move them)?	☐	☐	☐
Have vivid, dream-like scenes even though you know you are not totally asleep?	☐	☐	☐
Have any kind of pain or discomfort?	☐	☐	☐

How many times do you usually awaken each night? ______________________________

Do you have trouble getting back to sleep? ☐ Yes ☐ No

How long have you had you sleep problem? ______________________________

About sleeping

How often do you: *Check ONE BOX for each statement*	**Never**	**Sometimes**	**Often**
Feel afraid you won't return to sleep after awaking?	☐	☐	☐
Sleep with someone else in your bed?	☐	☐	☐
Have restless, disturbed sleep?	☐	☐	☐
Snore loudly?	☐	☐	☐
Sweat a lot during the night?	☐	☐	☐
Walk in your sleep?	☐	☐	☐
Fall out of bed while asleep?	☐	☐	☐
Wake up screaming, violent, or confused?	☐	☐	☐
Have unusual movements while asleep?	☐	☐	☐
Grind your teeth at night?	☐	☐	☐

Are you a: ☐ Sound sleeper ☐ Restless sleeper

My sleep is frequently disturbed by: *(check ALL that are true)*

- ☐ Heat
- ☐ Cold
- ☐ Noise – household/outside
- ☐ Noise or movement of your bedpartner
- ☐ Cough
- ☐ Shortness of breath
- ☐ Pets/Children
- ☐ Choking
- ☐ Indigestion, "gas' or heartburn
- ☐ Need to urinate
- ☐ Chest pain
- ☐ Frightening dreams
- ☐ Creeping, crawling or aching feelings in your legs (like you have to move them)

About waking up

How often do you: *Check ONE BOX for each statement*	Never	Sometimes	Often
Have a very hard time waking up?	☐	☐	☐
Feel unable to move when waking up?	☐	☐	☐
Have dream-like images when waking up even though you know you are not asleep?	☐	☐	☐
Wake up confused or disoriented?	☐	☐	☐
Wake up with a headache?	☐	☐	☐
Wake up sick to your stomach?	☐	☐	☐
Wake up feeling rested?	☐	☐	☐
Wake up 1 or 2 hours before you have to get up?	☐	☐	☐

About daytime functioning

Do you take naps? ☐ Yes ☐ No If yes, are they refreshing? ☐ Yes ☐ No

How long do you usually sleep during a typical nap? ______________________________

How often do you: *Check ONE BOX for each statement*	Never	Sometimes	Often
Feel sleepy during the day?	☐	☐	☐
Fall asleep unintentionally? Please give an example:	☐	☐	☐
Feel sad or depressed?	☐	☐	☐
Have anxiety? (worry about things)	☐	☐	☐
Feel weakness in your muscles when laughing, surprised, angry, excited, etc.?	☐	☐	☐

Other questions

Does anyone in your family have a sleep problem? ☐ Yes ☐ No

Relationship to you ______________________ Describe the problem ______________________

How much fluids do you drink?	During a typical day	Within 2 hours of bedtime
Coffee – Caffeinated	_______ Cups	_______ Cups
Coffee – Deaffeinated	_______ Cups	_______ Cups
Tea	_______ Cups	_______ Cups
Soda	_______ Cups	_______ Cups
Beer	_______ Cans	_______ Cans
Wine	_______ Glasses	_______ Glasses
Other alcoholic beverages	_______ Drinks	_______ Drinks

Do you smoke cigarettes?? ☐ Yes ☐ No

How much tobacco do you smoke during a 24 hour period? ______________________________

Medication history

Please list the name and dose (in mg.) of all medications you take NOW or WITHIN THE PAST 30 DAYS.

Medication	Dose	What for?

Medication history continued >

Please list the name of any pill for sleeping or to help you stay awake that you have taken in the PAST

Name **Did it help?**

Health history

Please check any problem or illness you have or have had:

- ☐ Heart disease
- ☐ Headache
- ☐ Black outs
- ☐ Dizziness
- ☐ Stroke (Aneurysm)
- ☐ Back trouble
- ☐ Asthma
- ☐ Cancer
- ☐ Seizures
- ☐ Incontinence
- ☐ Depression
- ☐ Tuberculosis
- ☐ High blood pressure
- ☐ Epilepsy
- ☐ Prosthesis (Artificial)
- ☐ Fainting
- ☐ Hemophilia
- ☐ Prostate trouble
- ☐ Bronchitis
- ☐ Allergies
- ☐ Kidney trouble
- ☐ Heartburn
- ☐ Diabetes
- ☐ Muscle cramps
- ☐ Impotence
- ☐ Bladder trouble
- ☐ Pneumonia
- ☐ Ulcers
- ☐ Arthritis

Please list any hospitalizations and/or surgeries you have had. *List the most recent first.* ______

Please list any allergies you have: ______

Work routine

How many hours a week do you work? ______

What are your usual work hours? From: ______ To: ______

Do you work different shifts now? ☐ Yes ☐ No If yes, describe: ______

Have you ever had a job which involved shift work? ☐ Yes ☐ No If yes, describe: ______

Describe your sleep problems

Use your own words to describe your sleep problems: ______