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THE EPWORTH SLEEPINESS SCALE

The Epworth Sleepiness Scale (ESS) was developed and validated by DR. Murray Johns of Melbourne, Australia. It is simple, self-administered questionnaire which is widely use by sleep professionals in quantifying the level of daytime sleepiness. (John MW. A new method for measuring daytime sleepiness: The Epworth Sleepiness Scale. Sleep 1991; 14(6): 540-5

Name:____Date: ____________________

How like are you to doze off or fall asleep in the following situations, in contrast to feeling just 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 work out how they would have affected you.

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
Sitting and reading	____________________
Watching TV	____________________
Sitting, inactive in a public place (e.g. A theatre or meeting)	____________________
As a passenger in a car for an hour without a break.	____________________
Lying down to rest in the afternoon when circumstances permit	____________________
Sitting and talking to someone	____________________
Sitting quietly after lunch without alcohol	____________________
In a car, while stopped for a few minutes in traffic	____________________

Total score: ____________________

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PATIENT QUESTIONAIRE FOR SLEEP APNEA AND SNORING

Name: ____ Age: _____ Sex: ____ Ht: _____ Wt: _____
Phone: ___________________ Work: ____________________

Please answer the following questions by indicating frequency according to these guidelines:

Daily	Every Almost every night or day
Often	At least once or twice per week
Infrequently	Less than once a week
Never	

During usual sleep, have you noticed or have been told that you do the following. (check one answer in each category)

	Daily	Often	Infreq	Never
A. Snore loudly	____	____	_____	_____
B. Choke struggle for breath or stop breathing	____	____	_____	_____
C. Awaken repeatedly because of a breathing problem	____	____	_____	_____
D. Toss and turn frequently	____	____	_____	_____
E. Kick or jerk legs repeatedly	____	____	_____	_____

When you wake up after usual sleep, how often do you experience the following:

	Daily	Often	Infreq	Never
A. Headache	____	____	_____	_____
B. Dry mouth	____	____	_____	_____
C. Feel tired or unrested	____	____	_____	_____

During the time when you are usually awake (daytime and evening), how often do you become irresistibly sleepy or do you fall asleep in the following situations:.

	Daily	Often	Infreq	Never
A. After meal	____	____	_____	_____
B. Reading or watching T.V.	____	____	_____	_____
C. At church or at school	____	____	_____	_____
D. At work	____	____	_____	_____
E. While passenger in a vehicle	____	____	_____	_____
F. While driving a vehicle	____	____	_____	_____

Do you have trouble breathing through your nose:

	Daily	Often	Infreq	Never
A. Daytime	____	____	_____	_____
B. Nighttime in bed	____	____	_____	_____

Do you consume an alcoholic beverage or take sedatives:

	Daily	Often	Infreq	Never
A. Daytime	____	____	_____	_____
B. Nighttime in bed	____	____	_____	_____

Have you had or used any of the following:
Nose broken Y__N__ Nose surgery Y__N__ Tosillectomy Y__N__

Hay Fever	Y__N__	Sinus Problem	Y__N__	Antihistamine	Y__N__
Cigarettes	Y__N__	Nasal spray	Y__N__	Prev. Treatment	Y__N__

Do you take any medication for?

Heart Condition	Y__N__	Respiratory Condition	Y__N__
Thyroid Condition	Y__N__	Metabolism (Weight)	Y__N__

1. How long have you been aware of your snoring? ____________________________
2. Has it caused problems for relatives/families? ______________________________
3. Have you been told your breathing stops while asleep?________________________
4. Have you been told you move around a lot while asleep? _____________________
5. What position do you sleep in? Side___ Back___ Stomach ___
6. About how many times at night do you wake up? ____________________________
7. Do you have any difficulty falling asleep at night? ___________________________
8. How many hours of sleep per night do you get? _____________________________
9. Do you often wake up feeling refreshed? __________________________________
10. Do you often wake up with headache? ____________________________________
11. Does a small amount of alcohol give you headache? ___________________________
12. Do you feel sleepy during the day? Frequently _______________
    Occasionally_______________
    Seldom or never ___________
13. What other doctors have you seen about snoring or apnea? ________________________
    ____
14. Have you had a sleep lab study? ____
15. Do you have difficulty breathing through your nose? ___________________________
16. Have you gained weight recently? _________________How much ? _______________
17. Present weight? ______________Height______________Feet___________Inches_______
18. Do you know if you have any heart irregularities? _______________________________
    ____
19. Do you have high blood pressure? ___________What is yours? ______________________
20. Do you have any loss of memory? ___________Depression? _________________________
21. Does your jaw joints click? _________________Stick? ________Hurt? _______________

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Signature: ___________________________________Date:____________________________