



Epworth Sleepiness Scale

Name: _____ Date of birth: _____ Today's date: _____
 Your age (Yrs): _____ Your sex (Male = M, Female = F): _____

This questionnaire assesses the likelihood that you will **doze** or **fall asleep** in certain situations. This is different from feeling tired and specifically pertains to feeling like you could literally fall asleep.

The questions refer to your usual way of life in **recent times**.

We want you to answer these questions to the best of your ability. Even if you haven't been in some of these situations recently (or ever), please indicate how you think they would affect 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

It is important that you answer each question as best you can.

Every question must have an answer.

| | CHANCE OF DOZING | | | |
|---|------------------|---|---|---|
| Sitting and Reading | 0 | 1 | 2 | 3 |
| Watching television | 0 | 1 | 2 | 3 |
| Sitting inactive in a public place (ex. a theater or a 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 without alcohol | 0 | 1 | 2 | 3 |
| In a car, while stopped for a few minutes in traffic | 0 | 1 | 2 | 3 |