

Name _____ Date _____

Assessment of Daytime Sleepiness: Epworth Sleepiness Scale

Please complete the questions below. This is a measure of dozing or falling asleep, not just feeling tired. This is to reflect how you have felt most recently.

Use the following scale to choose the most appropriate number.

0 = would never doze 2 = moderate chance of dozing

1 = slight chance of dozing 3 = high chance of dozing

It is important that you put a number (0-3) in each of the 9 boxes

<u>Situation</u>	<u>Chance of Dozing (0-3)</u>
Sitting and reading	
Watching television	
Sitting inactive in a public place, for example, A theater or meeting	
As a passenger in a car for an hour without a break	
Lying down to rest in the afternoon	
Sitting and talking to someone	
Sitting quietly after lunch (when you've had no alcohol)	
In a car, while stopped in traffic	
Total =	

Scoring: 1-6 enough sleep; 7-8 Average score; 9-up should consult sleep professional

The STOP Questionnaire

Y N 1. Do you SNORE loudly?

Y N 2. Do you often feel TIRED, fatigued or sleepy?

Y N 3. Have you been OBSERVED to stop breathing during sleep?

Y N 4. Are you being treated for or have high blood PRESSURE?

Answer positive to two (2) or more → High Risk for OSA