HOAG MEMORIAL HOSPITAL PRESBYTERIAN

EPWORTH SLEEPINESS SCALE
Sleep Disorders Center

Name: _____ Age: _____ Sex: M F Date: _____

Home Phone Number: _____ Work: _____

Please indicate the likelihood that you would fall asleep in the following situations (scale of 0-3). This refers to your **USUAL** way of life in recent times. 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. theater)	_____
As a passenger in a car for an hour without a break	_____
Lying down to rest in the afternoon when able	_____
Sitting and talking to someone	_____
Sitting quietly after lunch without alcohol	_____
In a car, while stopped for a few minutes in traffic	_____
Total	_____

Thank you for your cooperation.

_____ _____ _____
[Date] [Completed By] [Relationship to Patient]

Ref: Johns MW: Sept 1992
15-376-381

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PS 1711 07/18/03

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