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Southern California Pulmonary & Sleep Disorders Medical Center
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THE EPWORTH SLEEPINESS SCALE

Name:_____DOB_____DATE_____

Your age (years):_____ Your sex MALE or FEMALE (please circle)

How likely 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 **Please circle**	**Chance of Dozing**
Sitting and reading	0 1 2 3
Watching TV	0 1 2 3
Sitting, inactive in a public place (eg. 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 the traffic	0 1 2 3

TOTAL SCORE = _____

IF YOUR SCORE IS > 9, YOU ARE EXCESSIVELY SLEEPY AND MAY HAVE A SLEEP DISORDER. CONTACT US TO SET UP A CONSULTATION.

Thank you for taking our test.