Epworth Sleepiness Scale Questionnaire

Name: _____ Age: _____ Sex: M F

Date: _____ Height: _____ Weight: _____

The purpose of this questionnaire is to determine your level of sleepiness during the day. Sleepiness may indicate a medical condition which could make it difficult to get good quality sleep. **Please indicate the likelihood that you would fall asleep in the following situations (Scale of 0-3).** This refers to the 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 television	
Sitting, inactive in a public place (e.g. a theater or a meeting)	
As a passenger in a car for an hour without a break	
Lying down to rest in the afternoon when circumstanced permit	
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!