EPWORTH SLEEPINESS SCALE

Patient name:_____**DOB:**_____**Date:**_____

Use the following scale to choose the most appropriate number for each situation:

0 = would *never* doze or sleep.
1 = *slight* chance of dozing or sleeping
2 = *moderate* chance of dozing or sleeping
3 = *high* chance of dozing or sleeping

Sitting and reading	
Watching TV	
Sitting inactive in a public place	
Being a passenger in a motor vehicle for an hour or more	
Lying down in the afternoon	
Sitting and talking to someone	
Sitting quietly after lunch (no alcohol)	
Stopped for a few minutes in traffic while driving	
TOTAL SCORE (This is your Epworth Scale)	

Scoring:
1-6: Congratulations, you are getting enough sleep!
7-8: Your score is average
9 and up: Seek the advice of a sleep specialist without delay!

Sleep Survey

Name:_____ Date:_____

DOB:_____ Physician: Jeff Sandler, M.D.

1. Do you snore?
   ☐Yes ☐No ☐Don't Know

2. Has anyone ever noticed that you quit breathing or gasp for air during sleep?
   ☐Yes ☐No ☐Don't know

3. Does chest pain awaken you from sleep?
   ☐Yes ☐No

4. How often do you feel tired or fatigued after you sleep?
   ☐Every Day ☐at least 3x/week ☐less than 3x/week

5. Have you ever nodded off or fallen asleep while driving?
   ☐Yes ☐No

6. During your wake time do you feel tired, fatigued or in need of a nap?
   ☐Every Day ☐at least 3x/week ☐less than 3x/week

7. Have you ever had a sleep study?
   ☐Yes ☐No ☐Don't know

8. Do you sleep with a CPAP or BiPAP machine?
   ☐Yes ☐No

9. If yes, when did you last see a sleep doctor?
   ☐Within one year ☐Greater than one year ☐Never

Please check any of the following that apply to the patient:

☐Hypertension ☐Pacemaker ☐Family History of nocturnal cardiac death
☐Cardiac problems (history of heart attack or chest pains):

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