



**VALLEY INTENSIVISTS, PULMONOLOGISTS AND
SLEEP SPECIALISTS**

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EPWORTH SLEEPINESS SCALE

PATIENT INFORMATION:

Name: _____

Date of Birth: _____

Gender: Male Female Other

Date Completed: _____

INSTRUCTIONS

How likely are you to doze off or fall asleep in the following situations, as opposed to just feeling tired?

Consider your usual way of life in recent times.

Use the following scale:

- 0 = Would never doze
- 1 = Slight chance of dozing
- 2 = Moderate chance of dozing
- 3 = High chance of dozing

Situation	0	1	2	3
Sitting and reading	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Watching TV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting inactive in a public place (e.g., theater, meeting)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Passenger in a car for an hour without a break	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lying down to rest in the afternoon	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting and talking to someone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting quietly after lunch (no alcohol)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In a car, stopped in traffic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

FOR OFFICE USE ONLY

TOTAL SCORE (0-24): _____