Sleep Disorders Center

EPWORTH SLEEPINESS SCALE

Your Name: _____ Date of Birth: _____

Ordering Physician: _____ Date: _____

The following questions refer to how **sleepy** you usually feel. In contrast to just feeling tired, how likely are you to doze off or fall asleep in the following situations? (This refers to your usual life in recent times. Even if you have not done some of these things recently, try to recall how they have affected you.)

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

0 = No Chance 1 = Slight Chance 2 = Moderate Chance 3 = High Chance

Situation	Chance of Dozing
Sitting and reading	
Watching television	