CITRUS PULMONARY CONSULTANTS AND SLEEP DISORDERS CENTER
THE EPWORTH SLEEPINESS SCALE

Name: ____ Date of Birth: _______________

How likely are you to doze off or fall asleep in the following situations? If the question does not apply to you, please indicate how you feel sleepiness would affect you in that situation.

Use the following scale to indicate the most appropriate response for each situation.

0 – You would never doze off.
1 – Slight Chance of dozing off.
2 – Moderate Chance of dozing off.
3 – High chance of dozing off.

Situation	Score
While sitting or reading?	
While watching television?	
Sitting inactive in a public place?	
Riding in a car for one hour without a break?	
Lying down to rest in the afternoon?	
Sitting and talking to someone?	
Sitting quietly after lunch (without consuming any alcoholic beverage)?	
Stopped in traffic for a few minutes (as the driver)?	
Total:	

Please include any comments that you feel are important to the technologist or the physician to review.

____
____
____
____
____

____ _______________________
Patient Name Date