EPWORTH SLEEPINESS SCALE

Name: ____

Sponsors last 4 of SSN#: _______________ DOB: ________________

Today's Date: ____

Age (years): _______________________________

Gender (circle): MALE FEMALE

How likely are you to doze off or fall asleep in the following situation, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you.

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 (0-3)
Sitting and reading	0---1----2----3
Watching television	0---1----2----3
Sitting inactive in a public place, for example, a theater or meeting	0---1----2----3
As a passenger in a car for an hour without a break	0---1----2----3
Lying down to rest in the afternoon when cicumstances permit	0---1----2----3
Sitting and talking to someone	0---1----2----3
Sitting quietly after lunch without alcohol	0---1----2----3
Driving a car, while stopped for a few minutes in traffic	0---1----2----3

Name: ____________________________________ Sponsor's last 4 of SSN#__________________

Boise Sleep Laboratory
Naval Medical Center Portsmouth

BRIEF SLEEP HISTORY

What is your primary problem with your sleep?
____

Have others observed you sleeping? Y / N
If yes, what, if anything, have they told you about your sleep behavior?

____

____

____

Do you snore? N / Y. If yes, how badly? Circle one.

1. Can be heard in the bedroom
2. Can be heard outside the bedroom with the door closed
3. Can be heard outside the bedroom with the door closed
4. Can be heard on another floor of the home
5. You or your bed partner frequently needs to leave the bedroom

Do you have or are you being treated for any of the following medical conditions?
(Check those that apply)

a. High Blood Pressure (Hypertension) ______________
b. Diabetes (Abnormal blood sugar) _________________
c. Stroke ______________
d. Mini-stroke (TIA, transient ischemic attack) _________
e. Heart Attack (myocardial infraction)________________
f. Obstructive sleep apnea __________________________
g. Narcolepsy _________________

Have you had any of the following surgeries?
(Check those that apply)

h. Repair of nasal septum (septoplasty) _______________
i. Sinus surgery (Functional Endoscopic Sinus Surgery, turbinate reduction, etc.) _________________________
j. Tonsillectomy ________________
k. Uvulopalatopharyngoplasty (UPPP) _________________

Do you take any prescription medicines?
(Please list them below)

l. ____
m. ____
n. ____
o. ____
p. ____
q. ____
r. ____
s. ____
t. ____

Please check off below any of the listed problems you have on a regular basis, answer as best you can, there is no need to respond "no":

a. Weight gain in past year (lbs)_____ sweating in sleep ____ fatigue _
b. Watery eyes _________ Floppy lid syndrome _______
c. Stuffy nose _________ Postnasal drip _________
d. Chronic allergies ______ Dry mouth in the morning ________
e. Sore throat in the morning __________
f. Chest pains _________ palpitation ___________
g. Sleeping on more than one pillow because short of breath _____
h. Cough ___ Gasping at night __ Stopping breathing at night ___
i. Snoring ___ Heart burn/acid reflux _____ Stomach ulcers ____
u. Stomach bloating ___ Urinating more than once at night _____
v. Losing urine in bed ______ Frequent urination ______________

Name: ____________________________ Sponsor's last 4 of SSN# _______________

w. Varicose veins __________ leg/ankle swelling ______________
x. Goiter ____________ Thyroid disease __________________
y. Feeling hot when those around you are comfortable ________
z. Feeling cold when those around you are comfortable _______
aa. Increased thirst ______________
bb. Easy bruising ___________ Anemia or low iron ____________
cc. Drug allergies ___________ frequent infections ____________
dd. Use of anti-inflammatory steroids (Prednisone) _____________
ee. Strange sensations in legs at night _______________
ff. Sudden loss of muscle strength when laughing or upset _______
gg. Dreams when you are awake (other than daydreams) _________
hh. Waking from sleep with body *totally* paralyzed _____________
ii. Seizures/Fits ________ Sleep walking ____________
jj. Depression ____ Insomnia _____ Anxiety/panic attacks ______
kk. Headaches most mornings ________

Do any of your blood relatives have any of these medical problems?

High Blood Pressure (hypertension) __________________________

Sleep Apnea _____________________________

Narcolepsy ______________________________

Restless Leg Syndrome ____________________

Heart Attack before age 50 _________________

Do you drink any of the following beverages regularly (every day)?

a. Coffee YES / NO How many cups a day? _______________

b. Caffeinated soda pop YES / NO How many a day? ________________

c. Tea (hot,iced) YES / NO How many a day? ____________________

Do you work shifts or stand watches at night frequently? __________________

During the work week, what times do you usually go to bed? _______________

During your days off, what times do you usually go to bed? _______

During the weekends what times do you usually get out of bed? _____

Name: ___________________________ Sponsor's last 4 of SSN# _______________

Over the past 12 weeks, how often have you been bothered by any of the following problems? (Circle)

	Not at all	Several Days	More than half the days	Nearly every day
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3
Trouble falling or staying asleep, or sleeping too much	0	1	2	3
Feeling tired or having little energy	0	1	2	3
Poor appetite or overeating	0	1	2	3
Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
Moving or speaking so slowly that other people could have noticed. Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3

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