Epworth Scale and Patient History

Patient Name:		Date:	
Have you been told, or are Do you feel rested in the n Would you like more sleep	norning? YES or NO (c	eircle one)	? YES or NO (circle one)
Please answer how likely yo	u are to doze or fall asleep	n the following situati	ons. Use the scale provided below.
0 = Would Never Doze 1 =	Slight Chance of Dozing	2 = Moderate Chanc	e of Dozing 3 = High Chance of Dozing
Sitting and Reading		_	
Watching TV		_	
Sitting inactive in a movie/ n	neeting		
Riding in a car as a passenge Than an hour without a b			
Lying down to rest in the aft	ernoon	_	
Sitting and talking to someon	ne		
Sitting quietly after lunch wi	thout alcohol		
In a car, while stopped for a	few minutes in traffic		
	*Total Score:		
Please Height: Feet	e fill out the following q Inches	uestions to the best	of your knowledge.
Weight: Pounds *	BMI:		
*Neck Size: Inches			
*Waist Size: Inches	S		
Chief Complaint:			
Loud Snoring: N	ever Feel Rested:	Depr	ession:
Witnessed Apnea: D	ecreased Concentration:	High	Blood Pressure:
Obesity: F	requent Use of Bathroom a	t Night: Head	aches in Morning:
Wake up Coughing: I	Daytime Tiredness:	Weig	ht Gain: