Commonwealth ENT
Adult Sleep Questionnaire

The Epworth Sleepiness Scale

How likely are you to fall asleep as opposed to just feeling tired, in the following situations?
Base responses on your normal way of life in recent times. If you have not done some of these things recently, imagine what your response would be. Use the following choices:

0. **no** chance of dozing
1. **slight** chance of dozing
2. **moderate** chance of dozing
3. **high** chance of dozing

Situation	**Chance of Dozing**
Sitting and reading	__________
Watching Television	__________
Sitting, inactive in a public place such as a theatre or meeting	__________
As a passenger in a car or an hour without a break	__________
Lying down to rest in the afternoon when circumstances permit	__________
Sitting and talking to someone	__________
Sitting quietly after a lunch without alcohol	__________
In a car, while stopped a few minutes in the traffic	__________
Total Score – add all responses	__________

Have you had problems with excessive fatigue during the day?	YES____	NO ____
Have you experienced excessive daytime sleepiness?	YES____	NO ____
Are you easily distracted or unable to concentrate during the day?	YES____	NO ____
Has your work been compromised by your sleepiness?	YES____	NO ____
Have you had any auto accidents in the last 5 years?	YES____	NO ____
Do you feel sleepy on vacation?	YES____	NO ____
Do you feel sleepy even when you've slept long enough?	YES____	NO ____

Do you take naps during the day?	YES____	NO ____
Has anyone told you that you snore?	YES____	NO ____
Has anyone told you that you stop breathing while asleep?	YES____	NO ____
Do you snore in all sleeping positions?	YES____	NO ____

Have you ever awakened gasping for breath?	YES____	NO ____
Have you ever awakened with coughing or choking?	YES____	NO ____
Have you ever awakened with a sour taste?	YES____	NO ____
Have you ever awakened with chest tightness or discomfort?	YES____	NO ____
Do you often awaken with a sore throat?	YES____	NO ____
Have you gained any weight in the last five years?	YES____	NO ____
Do you take antacids?	YES____	NO ____
Have you had stomach pain, ulcers or indigestion?	YES____	NO ____

Do you have sudden episodes of sleep during the day?	YES____	NO ____
Have you ever felt unable to move while going to sleep?	YES____	NO ____
Do you kick your legs at night?	YES____	NO ____
Do you have difficulty falling asleep?	YES____	NO ____
Do you have difficulty staying asleep?	YES____	NO ____
Do you have restless sleep or frequent awakenings?	YES____	NO ____
Do you grind your teeth at night?	YES____	NO ____
Do you have pain that awakens you at night?	YES____	NO ____
Have you ever had any head trauma?	YES____	NO ____
Do you sleep walk?	YES____	NO ____
Do you wet the bed?	YES____	NO ____
Do you awaken to urinate frequently?	YES____	NO ____
Do you talk in your sleep?	YES____	NO ____
Do you have frequent nightmares? Ever awake screaming?	YES____	NO ____
Do you awaken to take care of someone else (infant, elderly)?	YES____	NO ____