



Epworth Sleepiness & Snoring Questionnaire

Patient Name: _____ Date of Birth: _____ Gender: _____

Height: _____ Weight: _____ lbs. Body Mass Index: _____

Please list your medical issues: for example (high blood pressure, diabetes, heart disease)

Circle if applicable

- | | | | |
|-----|---|-----|----|
| 1. | Do you snore? | Yes | No |
| 2. | Are you able to stay awake in the daytime? | Yes | No |
| 3. | Do you wake up with a headache in the morning? | Yes | No |
| 4. | Do you wake up unable to breathe or gasping for air? | Yes | No |
| 5. | Do you have sudden episodes where you lose muscle control? | Yes | No |
| 6. | Do your legs kick while you sleep or feel restless when drowsy? | Yes | No |
| 7. | Do you ever feel unable to move when falling asleep or waking up? | Yes | No |
| 8. | Do you have problems falling asleep? | Yes | No |
| 9. | Have you gained weight in a short time? | Yes | No |
| 10. | Do you have difficulty staying asleep? | Yes | No |
| 11. | Do you awaken with (please circle below-all that applies): | | |

- | | | |
|-----------|------------------|---------------------|
| Dry Mouth | Nasal Congestion | Headache |
| Heartburn | Chest Pain | Choking and Gasping |

EPWORTH SLEEPINESS SCALE

According to the following scale choose the appropriate number value to represent how likely you are to doze off or fall asleep during the day in the following situations:

Sitting and Reading	0	1	2	3
Watching TV	0	1	2	3
Sitting, inactive, in a public place	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	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after lunch without alcohol	0	1	2	3
In a car, while stopped for a few minutes in traffic	0	1	2	3

Total Score: _____