MODIFIED EPWORTH SLEEPINESS SCALE

Name:_____ Today's Date:_____

Date of Birth: _____ Age (Yrs): _____ Your Sex: _____

How likely are you to dose off or fall asleep in the following situations, in contrast to feeling just tired?

This refers to your usual way of life in recent times.

Even if you haven't 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	
Watching TV	
Sitting, inactive in a public place (e.g. a theatre or a meeting)	
As a passenger in a car for 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 for a few minutes in the traffic	

Do you Snore? Yes No

Have you been diagnosed with Obstructive Sleep Apnea? Yes No

Do you use a CPAP mask? Yes No