Epworth Sleepiness Scale

Name: _____ Today's date: _____

Your age (Yrs): _____ Your sex (Male = M, Female = F): _____

Referring: _____

How likely are you to doze 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

It is important that you answer each question as best you can.

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 _____	_____

PULMONARY AND SLEEP MEDICINE CONSULTANTS, P.C.
SLEEP DISORDERS CENTER
(AASM ACCREDITED)
700 Independence Circle Ste 3D Virginia Beach Va 23455
Tel:757-460-6080 fax:757-460-6081

Please complete the questionnaire and bring to your appointment scheduled for:

Chief Complaints

Please check the applicable symptoms:

☐ Difficulty falling asleep ☐ Staying asleep ☐ Snoring ☐ Choking or Gasping when awakening ☐ Not refreshed upon awakening ☐ Sleepy during the day ☐ Dry throat ☐ Dry mouth ☐ Nasal Congestion ☐ Postnasal drip ☐ Cough ☐ Wheezing ☐ Breathing pauses noted by bed partner ☐ Restless sleep ☐ Acting out during sleep ☐ Sleep talking ☐ Sleep walking ☐ History of nightmares ☐ Panic attacks etc. ☐Headaches

Is your problem getting (circle if applicable): **WORSE** **SAME** **IMPROVING**

Bedtime_____Wake up time_____

When do you get up? (Actually get out of bed)

_____

Do you sleep longer on weekends or holidays? **Yes No**

How long does it take for you to fall asleep?_____

Do you wake up at night?_____

If so… How many times?_____

Reasons for waking up at night?_____

Do you have difficulty getting back to sleep? **Yes No**

Do you suffer from unpleasant sensations(cramps ,tingling and numbness) in your legs? **Yes No**

Do you think you move your legs at night? **Yes No**

What was your weight 10 years ago_____?

How much tea, coffee, soda or alcohol do you drink per day_____?

Do you smoke? **Yes No**

PAST MEDICAL HISTORY

Diabetes	**Yes**	**No**	Controlled	Uncontrolled
Chest Pain	**Yes**	**No**	Controlled	Uncontrolled
Acid Reflux	**Yes**	**No**	Controlled	Uncontrolled
Bladder Problems	**Yes**	**No**		

DO YOU CURRENTLY HAVE SYMPTOMS OF:

Hypertension	**Yes**	**No**	Controlled	Uncontrolled
Excessive daytime Sleepiness	**Yes**	**No**		
Impaired Cognition	**Yes**	**No**		
Mood Disorders	**Yes**	**No**		
Insomnia	**Yes**	**No**		
Ischemic heart disease	**Yes**	**No**		
History of stroke	**Yes**	**No**		

PAST SURGICAL HISTORY

Please list all surgical procedures

_____

_____

Please list all medications and dosage you are currently taking
Are you allergic to any medications **Yes No**

_____ _____

_____ _____

_____ _____

_____ _____

FAMILY HISTORY

Circle if applicable

Sleep Apnea High Blood Pressure Diabetes Heart Disease Cancer Stroke Reflux Asthma High Cholesterol

Staff use only

Ht _____ **Wt**_____**B/P**_____ **Flu Shot**_____ **Pneu Shot**_____

Pulse_____ **O2**_____