



TRI COUNTY EAR, NOSE & THROAT, P.C.

EPWORTH SLEEPINESS SCALE (OPTIONAL)

Name: _____ Height: _____

Age: _____ Sex: M F Today's Date: _____ BMI: _____

Please indicate the likelihood that you would fall asleep in the following situations (Scale of 0-3). This refers to your usual way of life in recent times. 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
Sitting and reading	_____
Watching Television	_____
Sitting, inactive in a public place (e.g.: a theater 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 lunch without alcohol	_____
In a car, while stopped for a few minutes in traffic	_____
TOTAL	_____

Thank you for your cooperation!