TEXAS SINUS, ALLERGY, SNORING & SLEEP INSTITUTE

FOR SINUS, ALLERGY AND SLEEP MEDICINE EXCELLENCE

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Name: ____ Today's Date:__________

Date of Birth: _________________ Sex: Male / Female

EPWORTH SLEEPINESS SCALE

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Please score the following questions to the best of your ability giving the best response on the basis of your sleepiness or dozing off over the past 30 days. Use the following scale for choosing the most appropriate and honest number for each situation:

SITUATION			
Sitting and reading	**Yes**	**No**	______
Watching TV	**Yes**	**No**	______
Sitting, inactive in a public place (e.g. a theater or a meeting)	**Yes**	**No**	______
As a passenger in a car for an hour without a break	**Yes**	**No**	______
Lying down to rest in the afternoon when circumstances permit	**Yes**	**No**	______
Sitting and talking to someone	**Yes**	**No**	______
Sitting quietly after lunch without alcohol	**Yes**	**No**	______
In a car, while at a stop for a few minutes in traffic	**Yes**	**No**	______
TOTAL			______