

SLEEP ASSESMENT AND EPWORTH SCALE

Patient Name _____ Date of Birth _____

HT: _____ WT: _____ Age: _____ Daytime # _____

Please list any Medical Problems within the last 5 years(hypertension, Diabetes, Surgery, etc..)

Have you suffered from Heart Attack or Stroke? _____ When? _____

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|--|-----|----|--------------|
| 1. Do you snore at night | Yes | No | Occasionally |
| 2. Witnessed pauses inbreathing while asleep | Yes | No | Occasionally |
| 3. Do you have difficulty falling asleep | Yes | No | Occasionally |
| 4. Do you have difficulty maintaining sleep | Yes | No | Occasionally |
| 5. Experience a restless sensation in legs while lying awake in bed | Yes | No | Occasionally |
| 6. Kicking and twitching movements while asleep | Yes | No | Occasionally |
| 7. Experience excessive daytime tiredness | Yes | No | Occasionally |
| 8. Have you ever awakened feeling paralyzed | Yes | No | Occasionally |
| 9. Experience a sudden loss of strength in your arms or legs | Yes | No | Occasionally |
| 10. If previous answer is yes, were these events brought on by
A sudden frightening event or laughter | Yes | No | Occasionally |

Do you frequently awaken with: (please circle)

- Dry mouth Nasal Congestion Headache Heartburn Chest Pain
- Excessive sweating Choking and gasping Feeling Groggy or Un-refreshed

According to the following scale choose the appropriate number value to represent how likely you are to fall asleep during the day in the following situations. Try to be as honest as possible. If possible have your significant other help you fill this out.

0-Never	1-Slight Chance	2-Moderate	3-Always
Sitting and Reading	0	1	2 3
Watching T.V.	0	1	2 3
Sitting, Inactive in a public place(movie theatre, meeting)	0	1	2 3
Sitting and talking to someone	0	1	2 3
Sitting quietly after lunch without alcohol	0	1	2 3
As a passenger in a car for an hour without a break	0	1	2 3
Driving a vehicle for two or more hours	0	1	2 3
Lying down to rest in the afternoon when Circumstances permit	0	1	2 3

Total: _____