SLEEP ASSESSMENT AND EPWORTH SCALE

MEDICAL DIAGNOSIS IN LAST **5 YRS**:

☐ HYPERTENSION ☐ DIABETES ☐ STROKE ☐ HEART ATTACK ☐ SURGERY ☐GERD ☐

CURRENT MEDICATIONS: _____ _____

_____ _____

_____ _____

☐ I've been told that I snore

☐ I have been told that I hold my breath while I sleep

☐ I have high blood pressure

☐ My friends and family say that I'm often grumpy and irritable

☐ I wish I had more energy

☐ I anticipate a problem with sleep several times a week

☐ I worry about things and have trouble relaxing

☐ I lie awake for 30 mins. or more before falling asleep

☐ I have trouble concentrating

☐ I often feel like I'm in a daze

☐ I have vivid dreams soon after falling asleep and with naps

☐ I have episodes of momentarily feeling paralyzed

☐ I wake up at night with a "sour" taste in my mouth

☐ I have frequent sore throats

☐ I suddenly wake up feeling like I am choking

☐ I experience leg pain and/or cramps at night

☐ I often wake up gasping for breath

☐ I am overweight

☐ I feel sleepy and struggle to stay awake most days

☐ I frequently wake with a dry mouth

☐ I wake up with or get morning headaches

☐ I awaken and have trouble going back to sleep

☐ I wake up earlier in the a.m. than I would like

☐ I often worry because I can't sleep

☐ I have fallen asleep while driving

☐ I have fallen asleep at meetings/movies/parties

☐ I have "sleep attacks" during the day, no matter how hard I try to stay awake.

☐ I wake up at night coughing or wheezing

☐ I awaken frequently to urinate

☐ I've been told I kick and jerk during sleep

☐ I have an uncontrollable need to move my legs

☐ Even though I slept during the night, I feel sleepy during the day

According to the following scale, circle the appropriate number value to represent how likely you are to fall asleep

During the **day** in the following situations: **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 meeting/movie 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 vehicle passenger for more than an hour 0 1 2 3

Driving for two or more hours 0 1 2 3

Lying down to rest in the afternoon 0 1 2 3

TOTAL EPWORTH SCORE: _____/24 Greater than 10 indicates chronic/excessive sleepiness

NAME:_____ DATE _____