Print in Color or Grayscale Only
Using Adobe Acrobat Reader 8.0 or later

Patient Questionnaire

Please answer every question

Marking Instructions

Please use a # 2 pencil
Fill in the complete oval as shown...

PLEASE PRINT PATIENT'S LAST NAME

PLEASE PRINT PATIENT'S FIRST NAME

PATIENT'S DATE OF BIRTH

Month Day Year

Epworth Sleepiness Scale

How **likely** are you to **doze off or fall asleep** in the following situations? Even if you have not done some of these things recently, try to answer how these activities may affect you. Use the following scale to choose the most appropriate response for each situation:

(Fill in only one response for each question)

	Would Never Doze	Slight Chance of Dozing	Moderate Chance of Dozing	High Chance of Dozing
Sitting and reading	⬭	⬭	⬭	⬭
Watching television	⬭	⬭	⬭	⬭
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 traffic	⬭	⬭	⬭	⬭