Epworth Scale and Patient History

Patient Name: _____ Date: _____

Have you been told, or are you aware that you have a tendency to snore? **YES or NO** (circle one)
Do you feel rested in the morning? **YES or NO** (circle one)
Would you like more sleep? **YES or NO** (circle one)

Please answer how likely you are to doze or fall asleep in the following situations. Use the scale provided below.

0 = Would Never Doze 1 = Slight Chance of Dozing 2 = Moderate Chance of Dozing 3 = High Chance of Dozing

Sitting and Reading _____

Watching TV _____

Sitting inactive in a movie/ meeting _____

Riding in a car as a passenger for more
Than an hour without a break _____

Lying down to rest in the afternoon _____

Sitting and talking to someone _____

Sitting quietly after lunch without alcohol _____

In a car, while stopped for a few minutes in traffic _____

***Total Score: _____**

Please fill out the following questions to the best of your knowledge.

Height: _____ Feet_____ Inches

Weight: _____ Pounds *BMI: _____

*Neck Size: _____ Inches

*Waist Size: _____ Inches

Chief Complaint:

Loud Snoring: ____ Never Feel Rested: ____ Depression: ____

Witnessed Apnea: ____ Decreased Concentration: ____ High Blood Pressure: ____

Obesity: ____ Frequent Use of Bathroom at Night: ____ Headaches in Morning: ____

Wake up Coughing: ____ Daytime Tiredness: ____ Weight Gain: ____