



# Epworth Sleepiness Scale

(Patient Sticker)
OR
Full name: _____
Date of Birth: _____

Date completed: \_\_\_/\_\_\_/\_\_\_

This refers to your usual way of life in recent times:

**How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired?**

Even if you have not done some of these things recently, try to work out how they *would* have affected you.

Please use the following scale to choose the most appropriate number for each situation.

- 0 = would *never* doze**  
**1 = *slight* chance of dozing**  
**2 = *moderate* chance of dozing**  
**3 = *high* chance of dozing**

Situation	Chance of dozing			
	0	1	2	3
Sitting and reading	0	0	0	0
Watching TV	0	0	0	0
Sitting, inactive in a public place (e.g. a theatre or a meeting)	0	0	0	0
As a passenger in a car for an hour without a break	0	0	0	0
Lying down to rest in the afternoon when circumstances permit	0	0	0	0
Sitting and talking to someone	0	0	0	0
Sitting quietly after lunch without alcohol	0	0	0	0
In a car, while stopped for a few minutes in traffic	0	0	0	0
<b>Sum</b>				
<b>Findings</b>				