Conemaugh
Memorial Medical Center

Sleep Disorders Center

EPWORTH SLEEPINESS SCALE

Your Name: _____ Date of Birth: _____

Ordering Physician: _____ Date: _____

The following questions refer to how **sleepy** you usually feel. In contrast to just feeling tired, how likely are you to doze off or fall asleep in the following situations? (This refers to your usual life in recent times. Even if you have not done some of these things recently, try to recall how they have affected you.)

Use the following scale to choose the most appropriate number for each situation:

0 = No Chance 1 = Slight Chance 2 = Moderate Chance 3 = High Chance

Situation	Chance of Dozing			
Sitting and reading	0	1	2	3
Watching television	0	1	2	3
Sitting inactive in a public place (i.e., theater)	0	1	2	3
As a car passenger for an hour without a break	0	1	2	3
Lying down to rest in the afternoon	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after lunch without alcohol	0	1	2	3
In a car, while stopped for a few minutes in traffic	0	1	2	3

TOTAL SCORE