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THE EPWORTH SLEEPINESS SCALE (ESS)

How likely are you to dose off or fall asleep in the following situations?

	0	1	2	3
✓ **Please check one in each row:**	No chance	Slight chance	Moderate chance	High chance
Sitting and reading				
Watching TV				
Sitting inactive in a public in a public place (i.e. a theater or a meeting)				
Sitting and talking to someone				
As a passenger in a car for an hour without a break				
Lying down to rest in the afternoon when circumstances permit				
Sitting quietly after a lunch without alcohol				
In a car, while stopping for a few minutes in traffic				
TOTAL SCORE		*(add columns 0-3)*		

STOP QUESTIONNAIRE

(a quick questionnaire to see if you have an increased likeliness to have sleep apnea)

✓ **Please check either yes or no:**		**Yes**	**No**
S	Snoring – have you been told that you snore?		
T	Tired – Do you often feel tired, fatigued, or sleepy during the daytime?		
O	Observed – Do you know if you have stopped breathing or has anyone witnessed you stop breathing while sleeping?		
P	Pressure – Do you have high blood pressure or take medication to control high blood pressure?		

Have you ever had a sleep study? ☐ Yes ☐ No
Do you currently use a CPAP? ☐ Yes ☐ No

Patient name:_____ Age:_____ ☐ Male ☐ Female

Signature:_____Date:_____