

EPWORTH SLEEPINESS SCALE

The aim of this questionnaire is to get a measure of your sleepiness during the day. This helps distinguish between normal everyday tiredness and an abnormal level of sleepiness.

For each of the situations below please indicate how likely you are to doze off or fall asleep. This refers to your usual way of life in recent times. If your sleepiness is variable (for example, if you work shifts) then try and give an average. If you have not done some of these things, try and imagine how they would have affected you.

Use the following score to indicate the most appropriate answer.

- 0 – would never fall asleep in that situation
- 1 – there is a slight chance of falling asleep in that situation
- 2 – there is a medium chance of falling asleep in that situation
- 3 – there is a high chance of falling asleep in that situation

Situation	Chance of dozing off			
	0	1	2	3
1. Sitting and reading.				
2. Watching TV				
3. Sitting, inactive in a public place like a theatre or meeting				
4. As a passenger in a car for an hour without a break				
5. Lying down to rest in the afternoon when circumstances permit				
6. Sitting and talking to someone				
7. Sitting quietly after lunch without alcohol				
8. In a car, while stopped for a few minutes in traffic				

Once you have completed the questionnaire, add up your scores. A total score of up to 10 is regarded as indicating tiredness, whereas a score of 11 or more out of a maximum of 24 points indicates an unusual level of sleepiness

QUESTIONNAIRE FOR PARTNER

To help us decide whether your partner has any disorder of his or her breathing during sleep, it would be helpful if you could answer these questions. As most people are not aware of their breathing (and snoring) during sleep, any comments you have may be very helpful. Please use the back of this page if necessary.

Name of Patient: _____ Date completed: _____

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|---|-----------------------------|
| 1. Does your partner snore loudly in his or her sleep? | Yes/No |
| 2. Is the snoring sufficiently loud to wake you at night? | Yes/No |
| 3. Has the noise been bad enough for you to need to sleep in another room? | Yes/No |
| 4. Is the snoring worse if your partner has a blocked nose (e.g. with a cold) | Yes/No |
| 5. Does your partner seem to stop breathing in his or her sleep? | Yes/No |
| If so, can you give an idea of how many times per night this happens? | 1-10
11-20
20 or more |
| 6. Have you ever tried to waken your partner to make sure he/she is alright? | Yes/No |
| 7. Is your partner very restless while sleeping? | Yes/No |
| 8. Has your partner's personality changed recently? | Yes/No |
| If so, in what way? | |
| | |
| 9. Does your partner fall asleep easily during the day? | Yes/No |
| Has this occurred while driving? | Yes/No |
| 10. Any other comments? | |
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