DRS. GIRGIS & ASSOCIATES
Breathe Better, Hear Better, Sleep Better
630-528-9999 Fax: 630-427-6525
www.GirgisENT.com

Hinsdale Sleep Center

Epworth Sleepiness Scale

Patient Name: _____ Today's Date: _____ Pt Acct# _____

Instructions: *Please answer the questions below by checking the box that best describes you, based on how likely you are to fall asleep or doze in each situation.*

***Please refer to the last 2 weeks while using your sleep apnea treatment (for example, CPAP)**. If the last 2 weeks were unusual for any reason (e.g., illness), please consider the most recent 2-week period which you think most represents your current symptoms.*

Chance of Falling Asleep or Dozing ***Place a check mark in the appropriate box to the right for each item.***	**No Chance (0)**	**Slight Chance (1)**	**Moderate Chance (2)**	**High Chance (3)**
1. Sitting and reading				
2. Watching TV				
3. Sitting inactive in a public place (e.g. theater, 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				

Total Score on the Epworth Sleepiness Scale: _____