The Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situation, in contrast to feeling "just tired"? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you. Use the following scale to choose the most appropriate number for each situation.

Situation	Never Doze (0)	Slight Chance (1)	Moderate Chance (2)	High Chance (3)
Sitting and reading				
Watching TV				
Sitting, inactive in a public place (e.g. theater, meeting)				
As a passenger in a car for an hour without a break				
Lying down to rest in the afternoon when able				
Sitting and talking with someone				
Sitting quietly after a lunch without alcohol				
In a car, while stopped for a few minutes in traffic				

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Do you Snore? ❑ No ❑ Yes If yes, does your snoring bother others? ❑ No ❑ Yes

If you are currently using a CPAP / BiPAP machine, please fill out the following.

How long have you been on CPAP? _________ Do you feel you benefit from using it? ❑ No ❑ Yes

Do you use your CPAP/BiPAP nightly? ❑ No ❑ Yes How many hours do you wear it? _______

How many hours per night are you in bed? _______ How many hours are you asleep? ______

Are you feeling better than before you started treatment? ❑ No ❑ Yes

Do you exercise? ❑ No ❑ Yes How many days per week? ____________

Please circle the following:
The type of mask you are currently using: nasal pillow, nasal mask, or full-face mask

Which homecare company provided you with your equipment: OSA\Aerocare, Apria, Lincare, Medical Necessities, United Medical, American Home Patient, VA Or Other____________________________________

Has the company provided efficient / courteous service? ❑ No ❑ Yes

Has the company been available to help you with problems? ❑ No ❑ Yes

Any further comments? ____

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