Name: ______________________ Date: ______________

Email: ______________________ DOB: ______________

Height: ____________ Weight: ____________ M/F: ____________

EPWORTH SLEEPINESS SCALE

How often do you doze? (check one)	0	1	2	3
Sitting and reading?				
Watching television?				
Sitting in a public inactive place (theater or meeting)				
Riding in a car for one hour without a break (as a passenger)				
Lying down in the afternoon when circumstances permit				
Sitting and talking to someone				
Sitting quietly after lunch, without alcohol				
Stopped in traffic for a few minutes				

0 = no chance of dozing
1 = slight chance of dozing
2 = moderate chance of dozing
3 = high chance of dozing

TOTAL SCORE ______________

Signs & Symptoms

- Excessive Daytime Sleepiness
- Difficulty Staying Asleep
- Gasping/Choking
- Witnessed Apneas
- Morning Headaches
- Snoring
- Other ______________

Suspected Disorders

- Obstructive Sleep Apnea (OSA)
- Restless Leg Syndrome (RLS)
- Insomnia
- Narcolepsy

Medical History

- None
- Heart Disease
- Hypertension
- Stroke
- Diabetes
- Depression
- Anxiety
- Impaired Cognition
- Mood Disorders (Lack of focus)
- Other ______________

Current Medications & Allergies

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Please provide a copy of your Driver's License & Medical Insurance card(s).

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