EPWORTH SLEEPINESS SCALE

Modified—Morning-Afternoon-Evening

NAME: _____ **DATE:** _____

DOB: _____

In contrast to just feeling tired, how likely are you to doze off or fall asleep at each specified time of the day (in the morning, afternoon, and evening) in each of the following situations? Even if you have not done some of these things recently, try to work out how they would have affected you. For each time of the day, use the following scale to choose the most appropriate rating for each situation:

0= Would never doze
1= Slight chance of dozing
2= Moderate chance of dozing
3= High chance of dozing

Chance of Dozing

Situation	***Morning*** *Before noon*	***Afternoon*** *Noon-6pm*	***Evening*** *After 6 pm*
Sitting & reading……..			
Watching TV……			
Sitting inactive in a public place(i.e.theater)……			
As a car passenger for an hour without a break……			
Lying down to rest……			
Sitting & talking to someone……			
Sitting quietly after a meal without alcohol……			
In a car, while stopping for a few minutes in traffic……			
Total			