TRI COUNTY EAR, NOSE & THROAT, P.C.

EPWORTH SLEEPINESS SCALE
(OPTIONAL)

Name: ____ Height: ________________

Age: ____________ Sex: M F Today's Date: ____________________ BMI: __________________

Please indicate the likelihood that you would fall asleep in the following situations (Scale of 0-3). This refers to your usual way of life in recent tirnes. Use the following scale to choose the most appropriate number for each situation:

0: would never doze

1: slight chance of dozing

2: moderate chance of dozing

3: high chance of dozing

Situation	Chance of Dozing
Sitting and reading	_______________
Watching Television	_______________
Sitting, inactive in a public place (e.g.: a theater or a meeting)	_______________
As a passenger in a car for an hour without a break	_______________
Lying down to rest in the afternoon when circumstances permit	_______________
Sitting and talking to someone	_______________
Sitting quietly after lunch without alcohol	_______________
In a car, while stopped for a few minutes in traffic	_______________
TOTAL	_______________

Thank you for your cooperation!

©Copyright TRI COUNTY EAR, NOSE & THROAT, P.C., 2007
650 Park Street
Honesdale, PA 18431
570-253-0202
www.tricountyent.org