EPWORTH SLEEPINESS SCALE

Name: __________________________________________________

Sponsors last 4 of SSN#: _________________ DOB: _________________

Today’s Date: ___________________________________________

Age (years): ________________________________

Gender (circle):     MALE                         FEMALE

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:

0 = would never doze
1 = slight chance of dozing
2 = moderate chance of dozing
3 = high chance of dozing

<table>
<thead>
<tr>
<th>Situation</th>
<th>Chance of Dozing (0-3)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sitting and reading</td>
<td>0---1----2----3</td>
</tr>
<tr>
<td>Watching television</td>
<td>0---1----2----3</td>
</tr>
<tr>
<td>Sitting inactive in a public place, for example, a theater or meeting</td>
<td>0---1----2----3</td>
</tr>
<tr>
<td>As a passenger in a car for an hour without a break</td>
<td>0---1----2----3</td>
</tr>
<tr>
<td>Lying down to rest in the afternoon when circumstances permit</td>
<td>0---1----2----3</td>
</tr>
<tr>
<td>Sitting and talking to someone</td>
<td>0---1----2----3</td>
</tr>
<tr>
<td>Sitting quietly after lunch without alcohol</td>
<td>0---1----2----3</td>
</tr>
<tr>
<td>Driving a car, while stopped for a few minutes in traffic</td>
<td>0---1----2----3</td>
</tr>
</tbody>
</table>
Boise Sleep Laboratory
Naval Medical Center Portsmouth

BRIEF SLEEP HISTORY

What is your primary problem with your sleep?
_________________________________________________________________________________

Have others observed you sleeping?    Y / N
If yes, what, if anything, have they told you about your sleep behavior?
_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________

Do you snore?  N / Y. If yes, how badly?  Circle one.
1.  Can be heard in the bedroom
2.  Can be heard outside the bedroom with the door closed
3.  Can be heard outside the bedroom with the door closed
4.  Can be heard on another floor of the home
5.  You or your bed partner frequently needs to leave the bedroom

Do you have or are you being treated for any of the following medical conditions?
(Choose those that apply)

a.  High Blood Pressure (Hypertension)________________
b.  Diabetes (Abnormal blood sugar)__________________
c.  Stroke __________________
d.  Mini-stroke (TIA, transient ischemic attack)________
e.  Heart Attack (myocardial infraction)_______________
f.  Obstructive sleep apnea __________________________
g.  Narcolepsy ___________________
Have you had any of the following surgeries?
(Choose those that apply)

h. Repair of nasal septum (septoplasty) _______________

i. Sinus surgery (Functional Endoscopic Sinus Surgery, turbinate reduction, etc.) _______________

j. Tonsillectomy _______________

k. Uvulopalatopharyngoplasty (UPPP) _______________

Do you take any prescription medicines?
(If so, please list them below)
l. __________________________________________________
m. __________________________________________________

n. __________________________________________________
o. __________________________________________________
p. __________________________________________________
q. __________________________________________________
r. __________________________________________________
s. __________________________________________________
t. __________________________________________________

Please check off below any of the listed problems you have on a regular basis, answer as best you can, there is no need to respond “no”:
a. Weight gain in past year (lbs)____ sweating in sleep ____ fatigue _
b. Watery eyes ______ Floppy lid syndrome ______
c. Stuffy nose _______ Postnasal drip _________
d. Chronic allergies _____ Dry mouth in the morning ______
e. Sore throat in the morning ______
f. Chest pains _______ palpitation _________
g. Sleeping on more than one pillow because short of breath____
h. Cough ___ Gasping at night ___ Stopping breathing at night ___
i. Snoring ___ Heart burn/acid reflux _____ Stomach ulcers ___
u. Stomach bloating ___ Urinating more than once at night ____
v. Losing urine in bed ______ Frequent urination ____________

Name: ___________________________   Sponsor’s last 4 of SSN# _______________
w. Varicose veins __________ leg/ankle swelling ______________
x. Goiter __________ Thyroid disease ________________
y. Feeling hot when those around you are comfortable ______
z. Feeling cold when those around you are comfortable ______
   aa. Increased thirst ______________
   bb. Easy bruising __________ Anemia or low iron __________
   cc. Drug allergies __________ frequent infections __________
   dd. Use of anti-inflammatory steroids (Prednisone) ____________
   ee. Strange sensations in legs at night ______________
   ff. Sudden loss of muscle strength when laughing or upset ______
   gg. Dreams when you are awake (other than daydreams) ______
   hh. Waking from sleep with body totally paralyzed __________
   ii. Seizures/Fits ________ Sleep walking ______________
   jj. Depression ____ Insomnia ____ Anxiety/panic attacks _____
   kk. Headaches most mornings ______

Do any of your blood relatives have any of these medical problems?

   High Blood Pressure (hypertension) ______________________________
   Sleep Apnea ______________________________
   Narcolepsy ______________________________
   Restless Leg Syndrome __________________________
   Heart Attack before age 50 __________________________

Do you drink any of the following beverages regularly (every day)?

   a. Coffee YES / NO How many cups a day? ______________
   b. Caffeinated soda pop YES / NO How many a day? ______________
   c. Tea (hot, iced) YES / NO How many a day? ______________

Do you work shifts or stand watches at night frequently? ______________

During the work week, what times do you usually go to bed? ______________

During your days off, what times do you usually go to bed? ______

During the weekends what times do you usually get out of bed? _____

Name: ___________________________ Sponsor’s last 4 of SSN# _____________
Over the past 12 weeks, how often have you been bothered by any of the following problems? (Circle)

<table>
<thead>
<tr>
<th>Problem</th>
<th>Not at all</th>
<th>Several Days</th>
<th>More than half the days</th>
<th>Nearly every day</th>
</tr>
</thead>
<tbody>
<tr>
<td>Little interest or pleasure in doing things</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Feeling down, depressed, or hopeless</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Trouble falling or staying asleep, or sleeping too much</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Feeling tired or having little energy</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Poor appetite or overeating</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Feeling bad about yourself—or that you are a failure or have let yourself or your family down</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Trouble concentrating on things, such as reading the newspaper or watching television</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Moving or speaking so slowly that other people could have noticed. Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Thoughts that you would be better off dead, or of hurting yourself</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

Name: ___________________________   Sponsor’s last 4 of SSN# _______________