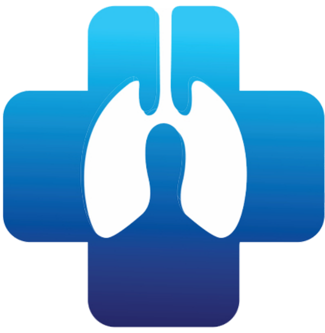


Advanced Respiratory & Sleep Medicine SKAND Corporation
Pulmonary/Critical Care/Neurocritical Care/Sleep Medicine
105 N. Bascom Ave. Suite. 202 San Jose, CA 95128
ARSMHealth.com
P: (408) 993-1500 F: (408) 993-1521

The Epworth Sleepiness Scale

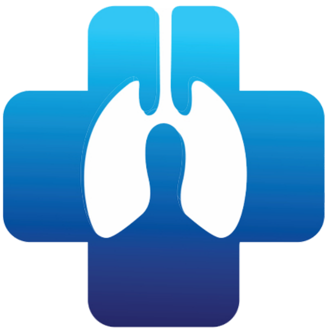
Patient Name: ____ DOB: ___________ Date: ____________

How likely are you to feel sleepy in the following situations; compared to just feeling 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:

Grading Scale:

0 = Would never feel sleepy
1 = *Slight* chance of being sleepy
2 = *Moderate* chance of being sleepy
3 = *High* chance of being sleepy

Situation	**Chance of Dozing**
Sitting and Reading	_________
Watching TV	_________
Sitting inactive in a public place (Park, Theater, 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 eating lunch without alcohol	_________
In a car while stopped for a few minutes in traffic	_________
ESS Total Points =	_________



Advanced Respiratory & Sleep Medicine

SKAND Corporation

Pulmonary/Critical Care/Neurocritical Care/Sleep Medicine

105 N. Bascom Ave. Suite. 202 San Jose, CA 95128

ARSMHealth.com

P: (408) 993-1500 F: (408) 993-1521

Sleep Evaluation Questionnaire

Patient Name: ______________________________ DOB: __________ Date: ___________

1. Do you snore severely? ☐Yes ☐No ☐Unsure
2. Have you been told that you stop breathing during sleep? ☐Yes ☐No ☐Unsure
3. Do you often (3-4 times a week) feel tired or fatigued? ☐Yes ☐No ☐Unsure
4. Do you have difficult - to control high blood pressure? ☐Yes ☐No ☐Unsure
5. Do you wake up gasping or choking? ☐Yes ☐No ☐Unsure
6. Do you experience aching/twitching in legs at bedtime? ☐Yes ☐No ☐Unsure
7. Do you experience pain/discomfort during sleep? ☐Yes ☐No ☐Unsure
8. Do headaches awaken you? ☐Yes ☐No ☐Unsure
9. Are you anxious or have racing thoughts at bedtime? ☐Yes ☐No ☐Unsure
10. Do others complain about your sleep? ☐Yes ☐No ☐Unsure
11. Do you have to wake up to use the restroom often? ☐Yes ☐No ☐Unsure
12. Have you ever been diagnosed with Sleep Apnea? ☐Yes ☐No ☐Unsure

    If so, what was the approximate date of diagnosis? ____________________

13. Have you ever completed a sleep study/polysomnography test? ☐Yes ☐No ☐Unsure

    If so, what was the approximate date of the test? ____________________

14. Do you currently use a CPAP/ APAP device? ☐Yes ☐No ☐Unsure

    Brand Name and Model: ______________________________

Patient Signature: ______________________________ Date: ___________