Patient Name;
Patient DOB:
Date:

Epworth Sleepiness Scale Questionnaire

This questionnaire was developed based upon the published findings of the American academy of Sleep Medicine(AASM). The purpose of this questionnaire is to aid a qualified medical professional in identifying possible symptoms of a sleep disorder and is not meant to be used as a substitute for any diagnostic procedure.

1.Have you been told you stop breathing while asleep?	Y/N	8
2.Have you ever fallen asleep or nodded off while driving?	Y/N	6
3.Have you ever woken up suddenly with shortness of breath, gasping or with your heart racing?	Y/N	6
4.Do you feel excessively sleepy during the day?	Y/N	4
5.Do you snore,or have you ever been told that you snore?	Y/N	4
6.Do you have trouble falling asleep?	Y/N	4
7.Do you have trouble staying asleep once you fall asleep?	Y/N	4
8.Do you kick or jerk your legs while you sleep?	Y/N	3
9.Do you feel burning,tingling or crawling sensations in your legs when you wake up?	Y/N	3
10.Do you wake up with headaches during the night or in the morning?	Y/N	3
11.Have you had weight gain or found it difficult to lose?	Y/N	2
12.Have you taken medication for, or been diagnosed with high blood pressure?	Y/N	2
Total Score:		

For Doctor/Staff USe Only

Low	Moderate	High	Severe
0-7	8-11	12-15	16+

Visual Indications

☐ **Enlarged/Scalloped Tongue** ☐ **Retruded Lower Jaw** ☐ **High Arching Hard Palate**
☐ **Bruxism** ☐ **Gastroesophageal Reflux** ☐ **Enlarged Tonsils** ☐ **Mouth Breather**

Have you ever been diagnosed with a sleep disorder? Yes or No
Are you currently using a CPAP machine? Yes or No
(if yes) Do you use it every night?

Notes: