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Name _____ Date _____ Age _____

___ Snoring: ___ Loud ___ Very Loud ___ Stop Breathing ___ Choking/Gasping for Air

___ Restless Legs ___ Sleep Walking ___ Sleep Talking ___ Nightmares

___ A.M. Headache ___ Dry Mouth ___ Fatigue ___ Tiredness

___ Excessive Daytime Sleepiness ___ Naps- how long? ___ hr. ___ Refreshed after nap?

___ Bedroom Rituals: ___ T.V. ___ Reading ___ Music

Time to Bed: _____ Sleep Onset: _____

of Awakenings _____ # of Bathroom visits: _____

___ Prior Sleep Evaluation-Name of Physician _____

___ Prior Sleep Study _____

___ Prior CPAP use/UPPP Procedure _____

THE EPWORTH SLEEPINESS SCALE

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

Situation

Chance of Dozing

Sitting and Reading..... _____

Watching TV..... _____

Sitting Inactive in Public Place (e.g. a theater or a meeting)..... _____

As a passenger in a car for an hour..... _____

Lying down to rest in the afternoon..... _____
(when circumstances permit)

Sitting and Talking to someone..... _____

Sitting quietly after lunch (w/out alcohol)..... _____

You're the driver, in a car stopped for few min.,..... _____