

THE EPWORTH SLEEPINESS SCALE

How likely are you to doze off or fall asleep in the following situations?

✓ Check one in each row:	0 No chance of dozing	1 Slight chance of dozing	2 Moderate chance of dozing	3 High chance of dozing
Sitting and reading	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Watching TV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting inactive in a public place (e.g. a theater or a meeting)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
As a passenger in a car for an hour without a break	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lying down to rest in the afternoon when circumstances permit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting and talking to someone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting quietly after a lunch without alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In a car, while stopped for a few minutes in traffic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Total Score: _____

(Add columns 0-3)

Patient Signature _____

Date _____

Berlin Questionnaire Sleep Evaluation

1. Complete the following:

height _____ age _____

weight _____ male/female _____

2. Do you snore?

- yes
 no
 don't know

If you snore:

3. Your snoring is?

- slightly louder than breathing
 as loud as talking
 louder than talking
 very loud. Can be heard in adjacent rooms

4. How often do you snore?

- nearly every day
 3-4 times a week
 1-2 times a week
 1-2 times a month
 never or nearly never

5. Has your snoring ever bothered other people?

- yes
 no

6. Has anyone noticed that you quit breathing during your sleep?

- nearly every day
 3-4 times a week
 1-2 times a week
 1-2 times a month
 never or nearly never

7. How often do you feel tired or fatigued after your sleep?

- nearly every day
 3-4 times a week
 1-2 times a week
 1-2 times a month
 never or nearly never

8. During your waketime, do you feel tired, fatigued or not up to par?

- nearly every day
 3-4 times a week
 1-2 times a week
 1-2 times a month
 never or nearly never

9. Have you ever nodded off or fallen asleep while driving a vehicle?

- yes
 no

If yes, how often does it occur?

- nearly every day
 3-4 times a week
 1-2 times a week
 1-2 times a month
 never or nearly never

10. Do you have high blood pressure?

- yes
 no
 don't know

(For office use)

Scoring Questions: Any answer within the box outline is a positive response

Scoring categories:

Category 1 is positive with 2 or more positive responses to questions 2-6

Category 2 is positive with 2 or more positive responses to questions 7-9

Category 3 is positive with 1 positive response and/or a BMI>30

(BMI = Body Mass Index)

Final Result: 2 or more possible categories indicates a high likelihood of sleep disordered breathing.