The Dentists' Office

GENTLE CARE THROUGH TECHNOLOGY

Feel free to print this and fill it out before coming in to our office. Might also be a good idea to give a copy to that spouse who snores!

Patient Name:_________________________________ **Date of Birth:**______________

EPWORTH SLEEPINESS SCALE

In contrast to just feeling tired, how likely are you to doze off or fall asleep in the following situations? 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 or 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 a public place (i.e., in a theatre)	___________
As a car passenger for an hour without a break	___________
Lying down to rest in the afternoon	___________
Sitting and talking to someone	___________
Sitting quietly after lunch (without alcohol)	___________
In a car, while stopping for a few minutes in traffic	___________
TOTAL SCORE =	___________

Have you had a sleep study? ________
Do you own a CPAP? ______ **If so, do you use it nightly?**_______

SIGNATURE:_______________________________________**DATE:**________________