University Ear, Nose and Throat Specialists, Inc.

Sleepiness Scale

Patient Name: ____ Today's Date: __________

MRN#: ____ DOB: ________________

Please check one:

□ Initial Visit □ After treatment for snoring or sleep apnea

Please answer the following questions:

How likely are you to doze off or fall asleep in the following situations, 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 check the box with 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

1. Sitting and reading__________________________________ □ 0 □ 1 □ 2 □ 3
2. Watching TV_______________________________________ □ 0 □ 1 □ 2 □ 3
3. Sitting, inactive in a public place (e.g. a theater or a meeting)__ □ 0 □ 1 □ 2 □ 3
4. As a passenger in a car for an hour without a break__________ □ 0 □ 1 □ 2 □ 3
5. Lying down to rest in the afternoon when circumstances permit □ 0 □ 1 □ 2 □ 3
6. Sitting and talking to someone_________________________ □ 0 □ 1 □ 2 □ 3
7. Sitting quietly after lunch without alcohol________________ □ 0 □ 1 □ 2 □ 3
8. In a car, while stopped for a few minutes in traffic__________ □ 0 □ 1 □ 2 □ 3

TOTAL = __________________________