Name_____ Date_____

Height_____ Weight_____

Do you experience any of these symptoms?

_ **Difficulty Concentrating**
_ **Excessive Daytime Sleepiness**
_ **Fatigue**
_ **Wake up not feeling refreshed**
_ **Morning Headaches**
_ **Dry Mouth or throat after waking up**
_ **Difficulty Losing Weight**
_ **Sleepiness While Driving**
_ **Frequent Naps**
_ **Snoring**
_ **Gasping or choking While Sleeping**
_ **Excessive Movement at Night**
_ **Waking up to Urinate**
_ **Grinding Teeth While Sleeping**
_ **Use of a sleep aid**
_ **CPAP intolerant**
_ **Use Nasal Spray daily or often**

___Insomnia
___Hypertension
____Diabetes
____Acid Reflux/GERD

Use the following scale to choose the most appropriate number for each situation:

- 0 = would never dose or sleep.
- 1 = slight chance of dozing or sleeping
- 2 = moderate chance of dozing or sleeping
- 3 = high chance of dozing or sleeping

Situation	Chance of dozing or sleeping
Sitting and reading	_____
Watching TV	_____
Sitting inactive in a public place	_____
Being a passenger in a motor vehicle for an hour or more	_____
Lying down in the afternoon	_____
Sitting and talking to someone	_____
Sitting quietly after lunch (no alcohol)	_____
Stopped for a few minutes in traffic while driving	_____
Total score (add the scores up) (This is your Epworth score)	_____