



**Eastern Carolina Internal Medicine  
Sleep Services**

**THE MODIFIED EPWORTH SLEEPINESS SCALE**

PATIENT NAME: \_\_\_\_\_

TODAY'S DATE: \_\_\_\_\_ AGE: \_\_\_\_\_ SEX: \_\_\_\_\_

TO THE PATIENT: Please complete this form and return it with the other forms.

How likely are you to doze off or fall asleep in the following situations, in the contrast to "just feeling tired?" This refers to your usual way of life in recent times. Even if you have done some of these activities recently, try to work out how they would affect 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

<u>SITUATION</u>	<u>CHANCE OF DOZING</u>
Sitting and reading	_____
Watching TV	_____
Sitting, inactive in a public place (theater, meeting, etc.)	_____
As a passenger in car for an hour without a break	_____
Lying down to rest in the afternoon (when circumstances permit)	_____
Sitting and talking to someone	_____
Sitting quietly after a lunch without alcohol	_____
In a car, while stopped for a few minutes in the traffic	_____

THANK YOU FOR YOUR COOPERATION