



**Eastern Carolina Internal Medicine
Sleep Services**

**THE MODIFIED EPWORTH SLEEPINESS SCALE
FOR YOUR BED PARTNER**

PATIENT NAME: _____

YOUR NAME (Bed partner): _____

TODAY'S DATE: _____ AGE: _____ SEX: _____

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

TO THE BED PARTNER: Please complete this form, giving us your observations of the patient's condition.

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

