Sleep Questionnaire (The Modified Epworth Sleepiness Scale)

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? This refers to your usual way of life in recent times. Even if you have not 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:

<table>
<thead>
<tr>
<th>Situation</th>
<th>Chance Of Dozing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sitting and reading</td>
<td></td>
</tr>
<tr>
<td>Watching TV</td>
<td></td>
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<tr>
<td>Sitting, inactive in a public place (theater, meeting, etc)</td>
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<tr>
<td>As a passenger in a car for an hour without a break</td>
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<tr>
<td>Lying down to rest in the afternoon when circumstances permit</td>
<td></td>
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<tr>
<td>Sitting and talking to someone</td>
<td></td>
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<tr>
<td>Sitting quietly after a lunch without alcohol</td>
<td></td>
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<tr>
<td>In a car, while stopped for a few minutes in the traffic</td>
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<tr>
<td><strong>Total points</strong></td>
<td></td>
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</tbody>
</table>

Please describe your sleep problem: _______________________________________

What time do you usually go to bed? _______________________________________

What is your work schedule? _______________________________________________

How long does it take you to fall asleep? ___________________________________

What do you usually do when you awaken during the night? ____________________

Do you have any unusual behavior during sleep of which you or others are aware? □ Yes □ No

If yes, please describe: __________________________________________________

Do you take naps? □ Yes □ No

What times? ____________________________ For how long? ______________________

Are your naps refreshing? □ Yes □ No
DO YOU:

Remember your dreams ☐ Yes ☐ No
Have vivid dream like scenes upon awakening or going to sleep ☐ Yes ☐ No
Feel unable to move when waking or falling asleep ☐ Yes ☐ No
Experience loss of muscle tone when extremely emotional ☐ Yes ☐ No
Snore ☐ Yes ☐ No
Sleep with your mouth open ☐ Yes ☐ No
Wake with dry mouth ☐ Yes ☐ No
Have breathing problems ☐ Yes ☐ No
Awaken at night with heartburn ☐ Yes ☐ No
Belching or cough/wheezing ☐ Yes ☐ No
Sweat excessively at night ☐ Yes ☐ No
Awaken with a headache ☐ Yes ☐ No
Are awakened by pain at night ☐ Yes ☐ No
Kick during the night ☐ Yes ☐ No
Experience crawling and aching feelings in your legs ☐ Yes ☐ No
Experience any kind of leg pain during the night ☐ Yes ☐ No
Grind teeth during sleep or jaw pain ☐ Yes ☐ No
Have nightmares ☐ Yes ☐ No
Have thoughts racing through your mind ☐ Yes ☐ No
Feel sad or depressed ☐ Yes ☐ No
Take something to help you sleep ☐ Yes ☐ No

For each of the beverages below, write in the average number you drink per day.

Caffeinated coffee ______ cups per day
Tea ______ cups/glasses per day
Soft drinks ______ cans or bottles per day
Alcohol average # drinks during the week ______ type ______
Alcohol average # drinks on the weekends ______ type ______