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▪ Epworth Daytime Sleepiness Questionnaire

Date: _____

Name: _____

The following question refers to your usual daily life in recent times:

How likely is it that you would doze off or fall asleep in the following situations — not just feel tired?

Even if you have not experienced some of these situations recently, please try to imagine how they would have affected you.

Please use the following scale to estimate as precisely as possible and tick the appropriate number:

0 = would never doze off

1 = slight chance of dozing

2 = moderate chance of dozing

3 = high chance of dozing

Situation	Likelihood of Dozing
Sitting and reading	☐ 0 ☐ 1 ☐ 2 ☐ 3
Watching TV	☐ 0 ☐ 1 ☐ 2 ☐ 3
Sitting inactive in a public place	☐ 0 ☐ 1 ☐ 2 ☐ 3
Passenger in a car for an hour	☐ 0 ☐ 1 ☐ 2 ☐ 3
Lying down to rest in the afternoon	☐ 0 ☐ 1 ☐ 2 ☐ 3
Sitting and talking to someone	☐ 0 ☐ 1 ☐ 2 ☐ 3
Sitting quietly after lunch	☐ 0 ☐ 1 ☐ 2 ☐ 3
Stopped in traffic while driving	☐ 0 ☐ 1 ☐ 2 ☐ 3
(Do not fill in) – Total	