WhidbeyHealth Sleep Care

WhidbeyHealth Sleep Care
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NAME: _____DATE:_____

EPWORTH SLEEPINESS SCALE

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently try to work out how they would have affected 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

SITUATION	**Chance of dozing**
Sitting and reading	0 1 2 3
Watching television	0 1 2 3
Sitting inactive in a public place, i.e. a theater or meeting	0 1 2 3
As a passenger in a car	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 (without alcohol)	0 1 2 3
In a car as a driver, while driving, or at a stop light in traffic	0 1 2 3

Please list the following: **Total:** _____

Allergies: _____

New Medications: _____

New medical conditions/procedures: _____

If you are a current CPAP/BiPAP user:

Who are you currently getting supplies from? (Circle):

Apria, CPAP Medical Supplies, Hoagland, Island Drug, Lincare, Nationwide, Norco,

Performance Home Medical, Rotech, Other:_____

Missed days of use due to:

❑ Family emergency ❑ Illness ❑ Mask issues ❑ Travel ❑ Other:_____

Current pressure : ❑ Too high ❑ Comfortable ❑ Too low

Mask Type: ❑ Full face ❑ Nasal pillows ❑ Nasal **Name:**_____

CPAP Issues/Concerns:

- ❑ Air blowing in eyes
- ❑ Bloated
- ❑ Bloody Nose
- ❑ Condensation in mask/hose
- ❑ Dry mouth/nose/throat
- ❑ Facial/mask discomfort
- ❑ Headache
- ❑ Mask leak noise
- ❑ Nasal congestion
- ❑ Snore while using device
- ❑ Other: _____