WhidbeyHealth Sleep Care
1300 N.E. Goldie Street, Oak Harbor, WA 98277
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www.whidbeyhealth.org

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

Total:________

Please list the following:

Allergies: ______________________________

New Medications: ______________________________

New medical conditions/procedures: ______________________________

Current CPAP/BiPAP user ONLY, complete below:

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

Apria, Bellevue Healthcare, Hoagland, Lincare, 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 **Mask 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: ______________________________

Patient label