EPWORTH SLEEPINESS SCALE

The Epworth Sleepiness Scale (ESS) is a simple, self-administered questionnaire and widely used by sleep professionals in quantifying the level of daytime sleepiness.

(Johns MW. A new method for measuring daytime sleepiness: The Epworth Sleepiness Scale. Sleep. 1991; 14:540-545.

NAME: _____ **Date:**_____

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 at present and in the recent past. 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**
1. Sitting and reading	_____
2. Watching television	_____
3. Sitting inactive in a public place (e.g. theater or meeting)	_____
4. As a passenger in a car for an hour without a break	_____
5. Lying down to rest in the afternoon when circumstances permit	_____
6. Sitting and talking to someone	_____
7. Sitting quietly after a lunch without alcohol	_____
8. In a car, while stopped for a few minutes in traffic	_____
TOTAL SCORE	_____

0-7 It is unlikely that you are abnormally sleepy
8-9 You have an average amount of daytime sleepiness
10-15 You may be excessively sleepy depending on the situation, and may want to consider seeking medical attention
16-24 You are excessively sleepy and should consider seeking medical attention

Stop-Bang Sleep Apnea Questionnaire

1. *S*noring
Do you *s*nore loudly (louder than talking or loud enough to be heard through closed doors)? **Yes No**

2. *T*ired
Do you often feel *t*ired, fatigued, or sleepy during daytime? **Yes No**

3. *O*bserved
Has anyone *o*bserved you stop breathing during your sleep? **Yes No**

4. Blood *p*ressure
Do you have or are you being treated for high blood *p*ressure? **Yes No**

5. *B*MI
***B*MI more than 35 kg/m2? (obese)** **Yes No**

6. *A*ge
***A*ge over 50 yr old?** **Yes No**

7. *N*eck circumference
***N*eck circumference greater than 40 cm?** **Yes No**

8. *G*ender
***G*ender male?** **Yes No**

***High risk of OSA:* answering yes to three or more items**
***Low risk of OSA:* answering yes to less than three items**

"sensitivity varied from 76% to 96%, and the specificity ranged from 13% to 54%." – ie. – will pick it up but lots other things can cause those problems like restless legs

Anesthesiology 2008; 108:812–21 STOP Questionnaire: A Tool to Screen Patients for Obstructive Sleep Apnea. Frances Chung et al

GAD-7

Over the last 2 weeks, how often have you been bothered by the following problems? *(Use "✔" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

(For office coding: Total Score T____ = ____ + ____ + ____)

HOSPITAL ANXIETY AND DEPRESSION SCALE

This questionnaire is designed to help your doctor know how you feel. Ignore the numbers printed on the left of the questionnaire. Read each item and underline the reply that comes closest to how you have been feeling in the last week. Don't take too long over your replies; your immediate reaction to each item will probably be more accurate than an exhaustively considered response.

A **I feel tense or "wound up"**
- 3 All of the time
- 2 A lot of the time
- 1 From time to time, occasionally
- 0 Not at all

D **I still enjoy things I used to enjoy**
- 0 Definitely as much
- 1 Not quite so much
- 2 Only a little
- 3 Hardly at all

A **I get a sort of frightened feeling as if something awful is about to happen**
- 3 Very definitely and quite badly
- 2 Yes, but not too badly
- 1 A little, but it doesn't worry me
- 0 Not at all

D **I can laugh and see the funny side of things**
- 0 As much as I always could
- 1 Not quite so much now
- 2 Definitely not so much now
- 3 Not at all

A **Worrying thoughts go through my mind**
- 3 A great deal of the time
- 2 A lot of the time
- 1 From time to time, but not too often
- 0 Only occasionally

D **I feel cheerful**
- 3 Not at all
- 2 Not often
- 1 Sometimes
- 0 Most of the time

A **I can sit at ease and feel relaxed**
- 0 Definitely
- 1 Usually
- 2 Not often
- 3 Not at all

D **I feel as if I am slowed down**
- 3 Nearly all of the time
- 2 Very often
- 1 Sometimes
- 0 Not at all

A **I get a sort of frightened feeling, like "butterflies in the stomach"**
- 0 Not at all
- 1 Occasionally
- 2 Quite often
- 3 Very often

D **I have lost interest in my appearance**
- 3 Definitely
- 2 I don't take as much care as I should
- 1 I may not take as much care
- 0 I take just as much care as ever

A **I feel restless, as though I have to be on the move**
- 3 Very much indeed
- 2 Quite a lot
- 1 Not very much
- 0 Not at all

D **I look forward with enjoyment to things**
- 0 As much as I ever did
- 1 Rather less than I used to
- 2 Definitely less than I used to
- 3 Hardly at all

A **I get sudden feelings of panic**
- 3 Very often indeed
- 2 Quite often
- 1 Not very often
- 0 Not at all

D **I can enjoy a good book, radio or TV program**
- 0 Often
- 1 Sometimes
- 2 Not often
- 3 Very seldom

A Total: _____ D Total : _____

Name: _____ Date: _____