TAKE THIS SIMPLE TEST: PRINT THE RESULTS AND SHOW THEM TO YOUR LOCAL DOCTOR.

It can help determine the quality of your sleep. If you experience the symptom on a regular basis, check "yes".

1. Do you snore loudly?

Yes ○ No ○

2. Do you stop breathing or gasp for breath while you sleep? You've been told this but don't remember when you wake up.

Yes ○ No ○

3. Do you have high blood pressure?

Yes ○ No ○

4. Do you hear from your friends and family that they have noticed changes in your personality?

Yes ○ No ○

5. Are you gaining weight?

Yes ○ No ○

6. Do you sweat excessively during the night?

Yes ○ No ○

7. Do you experience your heart pounding or beating irregularly during the night?

Yes ○ No ○

8. Do you get headaches in the morning?

Yes ○ No ○

9. Do you seem to be losing your sex drive?

Yes ○ No ○

10. Do you fall asleep during the day, even when you've had a good night's sleep?

Yes ○ No ○

11. Do you go limp when you experience strong emotions such as anger, fear,or surprise?

Yes ○ No ○

12. Do you fall asleep while driving, even after a good night's sleep?

Yes ○ No ○

13. Do you experience vivid dream-like scenes upon or soon after falling sleep?

Yes ○ No ○

14. Do you fall asleep during physical effort?

Yes No

15. Do you feel that you must cram in a full day into every hour to get anything done?

Yes No

16. Do you have trouble at work or school because of sleepiness?

Yes No

17. Do you sometimes feel totally paralyzed (unable to move) for brief periods when falling asleep or just after awakening?

Yes No

18. Do you still feel sleepy during the day, even though you slept through the night?

Yes No

19. Do you experience tension, aching, or crawling sensations in your legs other than when exercising?

Yes No

20. Are you ever told you kick at night?

Yes No

21. Do you experience leg pain during the day while trying to relax?

Yes No

22. Do you ever feel that you can't keep your legs still at night, or that you have to move them?

Yes No

23. Do you awaken with sore or aching muscles?

Yes No

24. Do thoughts race your through your mind and prevent you from sleeping?

Yes No

25. Do you wake up during the night and then can't go back to sleep?

Yes No

26. Do you worry about things and have trouble relaxing?

Yes No

27. Do you wake up earlier in the morning than you want to?

Yes No

28. Do you lie awake for half an hour or more before you fall asleep?

Yes No

29. Do you feel sad, depressed and afraid to go to sleep?

Yes ○ No ○

This simple test may be able to help you determine if you are having any problems. Review the guidelines which will help you identify your problem.

GUIDELINES: Questions 1-10 may be symptoms of Sleep Apnea (a pause in breathing which may occur many times a night and can be life threatening). Questions 10-18 may be symptoms of Narcolepsy (characterized by day-time sleep attacks). Questions 18-22 may be symptoms of Nocturnal Myoclonus and Restless Leg Syndrome (one leg jerking during the night). Questions 23-29 may be frequent symptoms found in patients with various types of Insomnia (the inability to fall asleep or stay asleep).

The Epworth Sleepiness Scale

Age (in years): ____
Height: _____
Weight: _____
Your sex: male __ female __

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

Sitting and reading:
0 ○ 1 ○ 2 ○ 3 ○

Sitting, inactive in a public place (e.g., a theater or a meeting):
0 ○ 1 ○ 2 ○ 3 ○

Watching TV:
0 ○ 1 ○ 2 ○ 3 ○

As a passenger in a car for an hour without a break:
0 ○ 1 ○ 2 ○ 3 ○

Lying down to rest in the afternoon when circumstances permit:
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, while stopped for a few minutes in traffic:

0 1 2 3

GUIDELINES: The Epworth Sleepiness Scale Age (in years): Your sex (male=M, female= F) 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: This test has been designed as a guideline to help you identify your problems.

Normal score is 8 on this test. If you score higher than 10 you have excessive daytime sleepiness.