Comprehensive Lung Care

www.mylungdoctor.net

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EPWORTH SCALE

Patient Name (Please Print): _____. **Date of Birth:** _____.

Gender	Height	Weight	Neck Circumference
○ Male ○Female	_____ft ____inch	_____ lbs	_____ inch

How likely are you to doze off or fall asleep in the following situations? How often do you feel 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 evaluate how they would affect you. Use the following scale to choose the most appropriate number for each situation:

Would **NEVER** doze: **0**	**SLIGHT** chance of dozing:**1**	MODERATE chance of dozing: **2**	**HIGH** chance of dozing: **3**

Situations	Chance of Dozing(0-3)
Sitting and reading.	
Watching TV	
Sitting, inactive, in a public place (e.g. a theater or a meeting)	
As a passenger in a car, for an hour without a break.	
Lying down to rest in the afternoon when circumstances permit.	
Sitting and talking to someone	
Sitting quietly after a lunch, without alcohol.	
In a car, while stopped for few minutes in traffic.	
Total Score Equals Your ESS (0-9 Average Score)	

Diagnosis: Obstructive Sleep Apnea (327.23/780.53)

Order: Home Sleep Test (HST), 95806.

G0399 (Tricare, Medicare and Medicaid Plans)

PATIENT'S SIGNATURE: _____. **DATE:** _____.