Sleep Scale

Patient Name: _____ Date: _____/_____/_____ Your Age: _____ (years)

This scale is meant to be a self-administered questionnaire used to assess your level of daytime sleepiness. It consists of eight different scenarios where you will rate your likelihood of falling asleep on a scale of 0 (would never doze) to 3 (high chance of dozing). Once completed and scored, this tool will help your provider to guide your diagnostic treatment plan.

SCORING KEY:

- **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	
Watching T.V.	
Sitting, inactive in a public place (ex. theater, meeting)	
As a passenger in a car for 1 hour without a break	
Lying down to rest in the afternoon when circumstances permit	
Sitting and talking to someone	
Sitting quietly after lunch without alcohol	
In a car, while stopped for a few minutes in traffic	
TOTAL:	