

Name: _____ Date: _____

Email: _____ DOB: _____

Height: _____ Weight: _____ M/F: _____

EPWORTH SLEEPINESS SCALE

How often do you doze? (check one)	0	1	2	3
Sitting and reading?				
Watching television?				
Sitting in a public inactive place (theater or meeting)				
Riding in a car for one hour without a break (as a passenger)				
Lying down in the afternoon when circumstances permit				
Sitting and talking to someone				
Sitting quietly after lunch, without alcohol				
Stopped in traffic for a few minutes				

0 = no chance of dozing

2 = moderate chance of dozing

TOTAL SCORE _____

1 = slight chance of dozing

3 = high chance of dozing

Signs & Symptoms

- Excessive Daytime Sleepiness
- Difficulty Staying Asleep
- Gasping/Choking
- Witnessed Apneas
- Morning Headaches
- Snoring
- Other _____

Suspected Disorders

- Obstructive Sleep Apnea (OSA)
- Restless Leg Syndrome (RLS)
- Insomnia
- Narcolepsy

Medical History

- None
- Heart Disease
- Hypertension
- Stroke
- Diabetes
- Depression
- Anxiety
- Impaired Cognition
- Mood Disorders (Lack of focus)
- Other _____

Current Medications & Allergies

Please provide a copy of your Driver's License & Medical Insurance card(s).



916-625-6591

hello@sleepdentistrocklin.com

www.sleepdentistrocklin.com

3111 Sunset Blvd, Suite X, Rocklin, CA 95677