Epworth Sleepiness Scale

Name:_____Today's date: _____

Your age (Yrs):_____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 haven't 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

It is important that you answer each question as best you can.

Situation	**Chance of Dozing (0-3)**
Sitting and reading	___
Watching TV	___
Sitting, inactive in a public place (e.g. a theatre 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 a few minutes in the traffic	___

THANK YOU FOR YOUR COOPERATION

Berlin questionnaire

Name _____
Address _____
_____

SLEEP EVALUATION

1 **Complete the following:**

height _____ age _____
weight _____ male/female _____

CATEGORY 1

2 **Do you snore?**

- ☐ yes
- ☐ no
- ☐ don't know

If you snore:

3 **Your snoring is?**

- ☐ slightly louder than breathing
- ☐ as loud as talking
- ☐ louder than talking
- ☐ very loud. Can be heard in adjacent rooms.

4 **How often do you snore?**

- ☐ nearly every day
- ☐ 3-4 times a week
- ☐ 1-2 times a week
- ☐ 1-2 times a month
- ☐ never or nearly never

5 **Has your snoring ever bothered other people?**

- ☐ yes
- ☐ no

6 **Has anyone noticed that you quit breathing during your sleep?**

- ☐ nearly every day
- ☐ 3-4 times a week
- ☐ 1-2 times a week
- ☐ 1-2 times a month
- ☐ never or nearly never

CATEGORY 2

7 **How often do you feel tired or fatigued after your sleep?**

- ☐ nearly every day
- ☐ 3-4 times a week
- ☐ 1-2 times a week
- ☐ 1-2 times a month
- ☐ never or nearly never

8 **During your wake time, do you feel tired, fatigued or not wake up to par?**

- ☐ nearly every day
- ☐ 3-4 times a week
- ☐ 1-2 times a week
- ☐ 1-2 times a month
- ☐ never or nearly never

9 **Have you ever nodded off or fallen asleep while driving a vehicle?**

- ☐ yes
- ☐ no

If yes, how often does it occur?

- ☐ nearly every day
- ☐ 3-4 times a week
- ☐ 1-2 times a week
- ☐ 1-2 times a month
- ☐ never or nearly never

CATEGORY 3

10 **Do you have high blood pressure?**

- ☐ yes
- ☐ no
- ☐ don't know

BMI =

Scoring Questions: Any answer within box outline is a positive response.

Scoring Categories: Category 1 is positive with 2 or more positive responses to questions 2-6 ☐
Category 2 is positive with 2 or more positive responses to questions 7-9 ☐
Category 3 is positive with 1 or more positive responses and/or a BMI>30 ☐

Final Results: 2 or more positive categories indicates a high likelihood of sleep disordered breathing.

EDWARD

REFERRAL COPY

Eating Attitudes Test (EAT-26)

Height_____ Current Weight_____ Highest Weight (excluding pregnancy) _____
Lowest Adult Weight_____

	Always	Usually	Often	Sometimes	Rarely	Never	Score
1. Am terrified about being overweight.							
2. Avoid eating when I am hungry.							
3. Find myself preoccupied with food.							
4. Have gone on eating binges where I feel that I may not be able to stop.							
5. Cut my food into small pieces.							
6. Aware of the calorie content of foods that I eat.							
7. Particularly avoid foods with a high carbohydrate content (i.e. bread, rice, potatoes, etc)							
8. Feel that others would prefer if I eat more.							
9. Vomit after I have eaten.							
10. Feel extremely guilty after eating.							
11. Am preoccupied with a desire to be thinner.							
12. Think about burning up calories when I exercise.							
13. Other people think that I am too thin.							
14. Am preoccupied with the thought of having fat on my body.							
15. Take longer than others to eat my meals.							
16. Avoid foods with sugar in them.							
17. Eat diet foods.							
18. Feel that food controls my life.							
19. Display self-control around food.							
20. Feel that others pressure me to eat.							
21. Give too much time and thought to food.							
22. Feel uncomfortable after eating sweets.							
23. Engage in dieting behavior.							
24. Like my stomach to be empty.							
25. Enjoy trying new rich foods.							
26. Have the impulse to vomit after meals.							

Please respond to each of the following questions. <u>Do not use ranges (i.e. 3-6 times).</u>

1) Have you gone on eating binges where you feel you may not be able to stop? (Eating much more than most people would eat under the same circumstances.)
   No _____ Yes _____ How many times in the last six months? _____

2) Have you ever made yourself sick (vomited) to control your weight or shape?
   No _____ Yes _____ How many times in the last six months? _____

3) Have you ever used laxatives, diet pills, or diuretics (water pills) to control your weight or shape?
   No _____ Yes _____ How many times in the last six months? _____

4) Have you ever been treated for an eating disorder?
   No _____ Yes _____ When (date)? _____

5) Have you recently thought of or attempted suicide?
   No _____ Yes _____ When (date)? _____