PEDIATRIC SLEEPINESS SCALE

EPWORTH SLEEPINESS SCALE FOR CHILDREN & ADOLESCENTS

Name: ______________________ DOB: ____________ Date: ____________

This questionnaire was developed to determine the level of daytime sleepiness in pediatric patients. You should help your child complete the questionnaire and review his or her responses with a doctor.

Over the past month, how likely have you been to fall asleep while doing the things that are described below (activities)? Even if you haven't done some of these things in the past month, try to imagine how they would have affected you.

Use the following scale to circle the number that best describes what has been happening to you during each activity over the past month.

0 Would ***never*** fall asleep

1 ***Slight*** chance of falling asleep

2 ***Moderate*** chance of falling asleep

3 ***High*** chance of falling asleep

Activity	Chance of Falling Asleep			
Sitting and reading	0	1	2	3
Sitting and watching TV or a video	0	1	2	3
Sitting in a classroom at school during the morning	0	1	2	3
Sitting and riding in a car or a bus for about half an hour	0	1	2	3
Lying down to rest or nap in the afternoon	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly by yourself after lunch	0	1	2	3
Sitting and eating a meal	0	1	2	3
Total Score:				

Higher scores are associated with more daytime sleepiness.
You should discuss your child's responses and score with a doctor.

This questionnaire is not intended to take the place of talking with a doctor. Regardless of the questionnaire results, if you have concerns about your child's symptoms, you are encouraged to discuss them with a doctor.

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