Sleep & Attention Disorders Institute

Epworth Sleepiness Scale (ESS) AND Sleepiness-Wakefulness Inability & Fatigue Test (SWIFT)

Name:____ **Filled out by:**_______________________ **Date:** ______________

If this is the first time you are filling this out, answer keeping in mind the last one month. Mark symptoms present only if they have been present for at least one month. If you have filled out this questionnaire before, answer based on the period of time since you last filled this out. Be sure to answer every question to the best of your ability. This questionnaire refers to your usual way of life in recent times. Even if you have not 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:

A. How much of a problem is it to stay awake during the day (or your usual wake period if you sleep during the day)?

	Not at all	Just a Little	Pretty Much	Very Much
1. Struggling to stay awake during the day	0:_____	1:_____	2:_____	3:_____
2. Difficulty staying awake while driving	0:_____	1:_____	2:_____	3:_____
3. Difficulty staying awake stopped at a traffic signal	0:_____	1:_____	2:_____	3:_____
4. Difficulty staying awake at work or while doing tasks	0:_____	1:_____	2:_____	3:_____
5. Difficulty staying awake while reading or studying	0:_____	1:_____	2:_____	3:_____
6. Difficulty staying awake in social situations	0:_____	1:_____	2:_____	3:_____

B. How much of a problem has fatigue, tiredness or lack of energy been for you?

	Not at all	Just a Little	Pretty Much	Very Much
1. Feeling tired when at work or while doing tasks	0:_____	1:_____	2:_____	3:_____
2. Lack of energy during social situations	0:_____	1:_____	2:_____	3:_____
3. Struggling with fatigue during the day	0:_____	1:_____	2:_____	3:_____
4. Feeling tired while reading or studying	0:_____	1:_____	2:_____	3:_____
5. No energy to do tasks that do not absolutely have to be done	0:_____	1:_____	2:_____	3:_____
6. Difficulty driving because of fatigue	0:_____	1:_____	2:_____	3:_____

C. How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired?

Chance of dozing	Never	Slight	Moderate	High
1. Sitting and reading	0:_____	1:_____	2:_____	3:_____
2. Watching TV	0:_____	1:_____	2:_____	3:_____
3. Sitting, inactive in a public place (e.g. a theater or a meeting)	0:_____	1:_____	2:_____	3:_____
4. As a passenger in a car for an hour without a break	0:_____	1:_____	2:_____	3:_____
5. Lying down to rest in the afternoon when circumstances permit	0:_____	1:_____	2:_____	3:_____
6. Sitting and talking to someone	0:_____	1:_____	2:_____	3:_____
7. Sitting quietly after a lunch without alcohol	0:_____	1:_____	2:_____	3:_____
8. In a car, while stopped for a few minutes in the traffic	0:_____	1:_____	2:_____	3:_____

Total GenWIF: A1+A4+A5+A6+B1+B2+B3+B4+B5____________ **DrivWIF: A2+A3+B6**_________ **ESS: Sum (C1:C8)**_____

Please mark any symptoms you currently have:

General		**Cardiovascular**		**Neurological**	
Appetite Decrease	:_______	Dizziness	:_______	Drowsiness	:_______
Appetite Increase	:_______	Palpitations	:_______	Difficulty sleeping	:_______
Ear Nose Mouth Throat		**Genitourinary**		**Psychiatric**	
Dry mouth	:_______	Difficulty with sexual arousal	:_______	Anxiety	:_______
Nasal congestion	:_______	Difficulty urinating	:_______	Irritability	:_______