Sleep & Attention Disorders Institute
(Accredited by American Academy of Sleep Medicine)
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Sleepiness-Wakefulness Inability & Fatigue Test (SWIFT) AND Epworth Sleepiness Scale (ESS)

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:____

Total: GenWIF: A1+A4+A5+A6+B1+B2+B3+B4+B5_____ **DrivWIF: A2+A3 +B6**_____

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 ESS: _____

Sleep & Attention Disorders Institute

Attention Deficit Rating Scale

Name: _____ **Filled out by:** _____ **Date:** _____

If this is the first time you are filling this out at this office, answer keeping in mind the last six months. Mark symptoms present only if they have been present for at least six months. If you have filled out this questionnaire before at this office, 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.

A.	**Never**	**Sometimes**	**Often**	**Frequent**
1. Fail to pay close attention to details, or makes careless mistakes in schoolwork, work or other activities	0:_____	1:_____	2:_____	3:_____
2. Difficulty sustaining attention in tasks or play activities	0:_____	1:_____	2:_____	3:_____
3. Not seeming to listen when spoken to directly	0:_____	1:_____	2:_____	3:_____
4. Not follow through on instructions and fail to finish schoolwork, chores, or duties at work	0:_____	1:_____	2:_____	3:_____
5. Difficulty organizing tasks and activities	0:_____	1:_____	2:_____	3:_____
6. Avoid, dislike or reluctant to do tasks that require sustained mental effort	0:_____	1:_____	2:_____	3:_____
7. Lose things necessary for tasks or activities	0:_____	1:_____	2:_____	3:_____
8. Easily distracted by extraneous stimuli	0:_____	1:_____	2:_____	3:_____
9. Forgetful in daily activities	0:_____	1:_____	2:_____	3:_____

B.	**Never**	**Sometimes**	**Often**	**Frequent**
1. Fidget with or tap hands or feet or squirm in seat	0:_____	1:_____	2:_____	3:_____
2. Leave seat in situations where remaining seated is expected	0:_____	1:_____	2:_____	3:_____
3. Run about or climb excessively in situations where it is inappropriate (in adults, may be limited to feeling restless)	0:_____	1:_____	2:_____	3:_____
4. Unable to play or engage in leisure activities quietly	0:_____	1:_____	2:_____	3:_____
5. "On the go", acting as if "driven by a motor"	0:_____	1:_____	2:_____	3:_____
6. Talk excessively	0:_____	1:_____	2:_____	3:_____
7. Blurt out an answer before a question has been completed	0:_____	1:_____	2:_____	3:_____
8. Difficulty waiting turn	0:_____	1:_____	2:_____	3:_____
9. Interrupt or intrude on others	0:_____	1:_____	2:_____	3:_____

C.	**Never**	**Sometimes**	**Often**	**Frequent**
1. Do symptoms rated above cause significant impairment or distress at home. school or work; with friends or relatives; in other activities	0:_____	1:_____	2:_____	3:_____

Total: A: _____ **B:** _____

STOP-Bang questionnaire

1.	Snoring: Do you snore loudly (loud enough to be heard through closed doors)?	Yes (_____)	No (_____)
2.	Tired: Do you often feel tired, fatigued, or sleepy during daytime?	Yes (_____)	No (_____)
3.	Observed: Has anyone observed you stop breathing during your sleep?	Yes (_____)	No (_____)
4.	Blood Pressure: Do you have or are you being treated for high blood pressure?	Yes (_____)	No (_____)

For office use only:

5.	*BMI: BMI more than 35 Kg/sq m?*	*Yes (_____)*	*No (_____)*
6.	*Age: Age over 50 yrs old?*	*Yes (_____)*	*No (_____)*
7.	*Neck circumference: Neck circumference >16"*	*Yes (_____)*	*No (_____)*
8.	*Gender: Male?*	*Yes (_____)*	*No (_____)*

Total: _____