Stony Brook Medicine

Sleep Disorders Center
240 Middle Country Road, Suite A
Smithtown, NY 11787
631-444-2500

Epworth Sleepiness Scale

*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 have not done some of these things recently, try to imagine how they would have affected you. Use the following scale to choose the most appropriate number for each situation:*

0	1	2	3
No chance of dozing	Slight chance of dozing	Moderate chance of dozing	High chance of dozing

1. Sitting and reading ..... _____
2. Watching TV ..... _____
3. Sitting inactive in a public place (e.g. theater or a meeting) ..... _____
4. As a passenger in a car for an hour without a break ..... _____
5. Lying down to rest in the afternoon when circumstances permit ..... _____
6. Sitting and talking to someone ..... _____
7. Sitting quietly after a lunch without alcohol ..... _____
8. In a car, while stopped for a few minutes in the traffic ..... _____

SUM _____

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Fatigue Severity Scale

Below are a series of statements regarding ***fatigue****. By fatigue we mean a* ***sense of tiredness, lack of energy or total body give-out****. Please read each statement and choose a number from 1 to 7, where number 1 indicates that you completely disagree with the statement and number 7 means you completely agree. Please answers this questions a they apply to the last two weeks:*

1	2	3	4	5	6	7
Complety Disagree						Completely Agree

1. Exercise brings on my fatigue ..... _____
2. I am easily fatigued ..... _____
3. Fatigue interferes with my physical functioning ..... _____
4. Fatigue causes frequent problems for me ..... _____
5. My fatigue prevents sustained physical functioning ..... _____
6. Fatigue interferes with carrying out certain duties and responsibilities .. _____
7. Fatigue is my most disabling symptom ..... _____
8. Fatigue is among my 3 most disabling symptoms ..... _____
9. Fatigue interferes with my work, family or social life ..... _____
10. Fatigue makes other symptoms worse ..... _____

SUM _____

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Body Sensations Questionnaire

*Below is a list of feelings, sensations, problems, and experiences that people sometimes have. Read each item and use the 1 to 5 scale below to select a rating that best describes **how much** you have felt or experienced things this way **during the past week, including today**. Use this scale when answering and select just one number for each item:*

1	2	3	4	5
Not at all	A little bit	Moderately	Quite a bit	Extremely

1. Startled easily ..... _____
2. Hands were shaky ..... _____
3. Was short of breath ..... _____
4. Felt faint ..... _____
5. Had hot or cold spells ..... _____
6. Hands were cold or sweaty ..... _____
7. Was trembling or shaking ..... _____
8. Had trouble swallowing ..... _____
9. Felt dizzy or lightheaded ..... _____
10. Had pain in my chest ..... _____
11. Felt like I was choking ..... _____
12. Muscles twitched or trembled ..... _____
13. Had a very dry mouth ..... _____
14. Was afraid I was going to die ..... _____
15. Felt heart racing, pounding or palpitations ..... _____
16. Felt numbness or tingling in my body ..... _____
17. Had to urinate frequently ..... _____

SUM _____