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Daily Sleep Questionaire
(Epworth Sleepiness Scale)

Surname: _____

Date: _____ Signature: _____

Pat.-Nr.: _____

The following questions relate to your recent normal daily life:

How likely are you to nod 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. It is important that you answer each question as best you can.

Use the following scale to choose the most appropriate number for each situation.

0 = Would Never nod off
1 = *Slight chance of nodding off*
2 = Moderate chance of nodding off
3 = *HIgh chance of nodding off*

Situation	Probability to nod off
Sitting and reading	⓪ ① ② ③
Watching TV	⓪ ① ② ③
Sitting, inactive, in a public place (e.g., in a meeting, theater, or dinner event)	⓪ ① ② ③
As a passenger in a car for an hour or more without stopping for a break	⓪ ① ② ③
Lying down to rest when circumstances permit	⓪ ① ② ③
Sitting and talking to someone	⓪ ① ② ③
Sitting quietly after a meal without alcohol	⓪ ① ② ③
In a car, while stopped for a few minutes in traffic or at a light	⓪ ① ② ③
Please do not fill out Total:	

The Pittsburgh Sleep Quality Index (PSQI)

Instructions: The following questions relate to your usual sleep habits during the past month only. Your answers should indicate the most accurate reply for the majority of days and nights in the past four weeks. Please answer all questions.

During the past four weeks:

1. When have you usually gone to bed? _____

2. How long has it taken you to fall asleep each night?

in minutes: _____

3. When have you usually gotten up in the morning? Usual time: _____

4. How many hours of actual sleep do you get at night? (This may be different than the number of hours you spend in bed).

Effective sleep time per night in hours: _____

5. During the past four weeks, how often have you had trouble sleeping because you, …. **(Please check)**

	Not during the past four weeks	Less than once a week	Once or twice a week	Three or more times a week
… cannot get to sleep within 30 minutes?				
… wake up in the middle of the night or early morning?				
… have to get up to use the bathroom?				
… cannot breathe comfortably?				
… cough or snore loudly?				
… feel to cold?				
… feel to hot?				
… have bad dreams?				
… have pain?				
… other reason(s)? Please describe, including how often you have hat trouble sleeping because of this reason(s)				

6. During the past four weeks, how would you rate your sleep quality overall?

○ **Very good** ○ **Fairly good** ○ **Fairly bad** ○ **Very bad**