


SUPPLEMENT SHEET
Driver's License Regulation or G 25
"Driving, control and monitoring activities"
Please fill out the form and bring it along to the examination.
The information on this questionnaire and the findings obtained are subject to medical confidentiality
Last name, first name:
Date/place of birth:
Employer:

Daytime Sleepiness Questionnaire (Epworth)
The following questions relate to your normal day-to-day life over the last while:

Please answer all questions in a way that faithfully reflects your recent experience of the situation described in each case. The questions are generally about your personal assessment of how likely it is for you to nod off or even fall asleep in the situations described. They are not simply asking whether you feel tired. If you are asked about situations you have not experienced at all, please give an answer that reflects what would likely have happened.

Please use the following scale for your answers.
Please select the number that best fits the situation described.
0 = would never nod off

2 = **medium likelihood** of nodding off

1 = **low** likelihood of nodding off **3** = **high** likelihood of nodding off

Situation	Likelihood of nodding off			
	(Tick number)			
Reading while sitting	0	1	2	3
Watching television	0	1	2	3
When sitting passively (as a listener) in public (e.g. in a theatre, during a lecture)	0	1	2	3
As a passenger in a car during a one-hour drive without a break	0	1	2	3
When you lie down for a rest in the afternoon	0	1	2	3
When you are sitting and talking to someone	0	1	2	3
When you are sitting quietly after lunch (without any alcohol)	0	1	2	3
When you are driving a car and are caught in a traffic jam for a few minutes	0	1	2	3
Total: (please do not fill out)				

		Yes	No	not known
1.	Do you snore frequently (almost every night or more than three times a week) or does your partner report this to you?			
2.	Do you briefly stop breathing during sleep (sleep apnea) or does your partner report this to you?			
3.	Do you feel drowsy during the day? (Do you have trouble keeping your eyes open or fall asleep unintentionally?)			
4.	Have you ever momentarily nodded off (experienced micro-sleep) at work? Have you ever fallen asleep at the wheel?			

(Source: Arbeitsmedizinische Vorsorge, 6th, completely revised edition p. 382, Gentner Verlag)

I confirm that the information I have provided is correct.

Date: _____ Signature: _____