EPWORTH SLEEPINESS SCALE (ESS)

The following questionnaire will help you measure your general level of daytime sleepiness. You are to rate the chance that you would *doze off or fall asleep* during different routine daytime situations. Answers to the questions are rated on a reliable scale called the Epworth Sleepiness Scale (ESS). Each item is rated from 0 to 3, with 0 meaning you would never *doze or fall asleep* in a given situation, and 3 meaning there is a very high chance that you would *doze or fall asleep* in that situation.

How likely are you to *doze off or fall asleep* in the following situations, in contrast to just feeling tired? Even if you haven't done some of the activities recently, think about how they would have affected you.

Use this scale to choose the most appropriate number for each situation:

0 = would never doze
1 = slight chance of dozing
2 = moderate chance of dozing
3 = high chance of dozing

It is important that you circle a number (0 to 3) for EACH situation.

SITUATION	**CHANCE OF DOZING**			
Sitting and reading	0	1	2	3
Watching television	0	1	2	3
Sitting inactive in a public place (theater/meeting)	0	1	2	3
As a passenger in a car for an hour without a break	0	1	2	3
Lying down to rest in the afternoon	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after lunch (with no alcohol)	0	1	2	3
In a car, while stopped in traffic	0	1	2	3

TOTAL SCORE _____

Name: _____

Date: _____

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Questionnaire for Smoking Cessation Clinic (First visit)

Please measure your blood pressure after filling out the questionnaire sheet. Submit the sheet to the physician during your consultation.

Q1. Do you currently smoke?

- ☐ Yes
- ☐ I quit smoking (years ago/ months ago)
- ☐ I do not smoke

If "Yes", please answer the following questions.

Q2. On average, how many cigarettes do you smoke in a day? _____ sticks/day

Q3. How long has it been since you started smoking habitually? _____ years

Q4. Have you ever tried to quit smoking in the past? NO / YES (time/s)

Q5. What is the longest period that you have gone without smoking? _____ day/s

Q6. Why did you decide to visit our smoking cessation clinic?

(check all that apply)

- ☐ Damaged your health; felt sick
- ☐ You thought it's not good for your future health
- ☐ Economic reasons
- ☐ Recommendation from family or acquaintance
- ☐ Advice from your physician
- ☐ It disturbs other people
- ☐ Lowering social acceptability of smoking
- ☐ Others ( )

Q7. Are you currently undergoing treatment or have been treated for the following diseases? (check if applicable)

- ☐ High blood pressure ☐ Angina ☐ Cardiac Infarction ☐ Arrhythmia
- ☐ Diabetes ☐ Cerebral stroke (hemorrhage, cerebral infarction)
- ☐ Hyperlipidemia (cholesterol, neutral fat) ☐ Bronchial asthma ☐ Emphysema
- ☐ Chronic bronchitis ☐ Lung fibrosis (interstitial pneumonia)
- ☐ Tuberculosis, Gastroduodenal ulcer ☐ Gastritis
- ☐ Cancer, Malignant Tumor (Body part:)
- ☐ Others ( )

Q8. Is there anyone in your household that smokes? YES / NO

relationship ( )

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Q9. Occupation (　　)

Q10. Do you work in a non-smoking office?
YES / NO (We have a separated smoking rooms / Smoking is allowed)

Q11. Your current height (　　) cm　　Weight (　　) Kg

Q12. Please answer the below regarding your **mental state**.
(1) Please circle the below number that best averages how difficult the past week has been for you.
Not at all　0　1　2　3　4　5　6　7　8　9　10　Extremely
(2) To what extent did that difficulty affect your daily life?
Not at all　0　1　2　3　4　5　6　7　8　9　10　Extremely

Q13. Read the questions below and put a circle to the applicable answer.

	Questions	YES (1 point)	No (0 point)
1	Do you have experience smoking more than you initially intended?		
2	Have you ever failed when you tried to quit smoking or decrease the amount of cigarettes?		
3	Have you ever craved to smoke when you tried to quit smoking or decrease the amount of cigarettes?		
4	Have you ever experienced any of the symptoms below when you tried to quit smoking or decrease the amount of cigarettes? (Frustration, Nervousness, Restlessness, Distracted, melancholic, Headache, Sleepiness, Upset stomach, Slow pulse, Shaky hands, Increase in appetite or weight)		
5	Have you ever started smoking again to relieve the symptoms in Q4?		
6	Have you ever smoked even after knowing you have a heavy disease and it is not good for you?		
7	Have you ever smoked knowing you have health problems caused by smoking?		
8	Have you ever smoked knowing you have a mental problem caused by smoking?		
9	Have you ever felt that you are addicted to smoking?		
10	Have you ever avoided a job or a social obligation where you cannot smoke?		
	Total		

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