

# Sleep Disorders Research Questionnaire

-Stanford University Center for Narcolepsy and Related Disorders-

Thank you for taking the time to contribute to sleep disorders research. Please complete this questionnaire **as though you were untreated for any sleep disorder**, unless otherwise specified; in many cases, patients with sleep disorders notice a temporary increase in symptoms, known as “rebound”, upon abrupt cessation of therapy. Given this possibility, **please imagine your situation either prior to treatment or after a lengthy cessation of treatment** (after the rebound has run its course). Please call 650-721-7550 if you need assistance.

## SECTION I: Demographics

Date Completed:

\_\_\_\_ / \_\_\_\_ / \_\_\_\_

NAME: \_\_\_\_\_  
*Last First Middle Initial*

ADDRESS: \_\_\_\_\_  
*Street Address*

\_\_\_\_\_  
*City State Zip Code Country*

TELEPHONE: (\_\_\_\_) \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_  
*Home Work Cellular*

E-MAIL ADDRESS: \_\_\_\_\_

BIRTH DATE: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ CURRENT AGE: \_\_\_\_\_  
*month/day/year*

GENDER:  Male  Female

HEIGHT: \_\_\_\_ / \_\_\_\_  feet/inches  meter/centimeter

WEIGHT: \_\_\_\_\_  pounds  kilograms

## Personal History:

Where were you born? \_\_\_\_\_  
*City State/Province Country*

With which of the following major ethnic groups do you identify?

*Check ALL THAT APPLY and specify the country/countries of origin of yourself and ancestors for each group checked. For example, if you consider yourself Asian, specify whether Chinese, Korean, etc. If you consider yourself American, please specify your family's country/countries of origin prior to immigrating to the United States. If you mark other, please specify.*

American Indian \_\_\_\_\_  Asian \_\_\_\_\_  
 Black \_\_\_\_\_  Caucasian \_\_\_\_\_  
 Latino \_\_\_\_\_  Jewish  Ashkenazi  Sephardic  Other \_\_\_\_\_  
 Pacific Islander \_\_\_\_\_  Other \_\_\_\_\_

**Sample History (if available):**

DATE OF BLOOD DRAW: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
*month/day/year*

TIME OF BLOOD DRAW: \_\_\_\_\_ *am / pm*

DATE OF CSF DRAW: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
*month/day/year*

TIME OF CSF DRAW: \_\_\_\_\_ *am / pm*

REASON FOR CSF DRAW: \_\_\_\_\_

**SECTION II: Medical History**

1. Please list all medical problems that **CURRENTLY** affect you, including narcolepsy and other sleep disorders. Please indicate whether each condition has or has not been diagnosed by a physician.

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2. Please list all medications (with doses) that you are **CURRENTLY** taking, including those for narcolepsy and other sleep disorders.

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3. Please list all significant medical problems that you had **IN THE PAST** (for example surgery) including narcolepsy and other sleep disorders.

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**Developmental History:**

4. At what approximate age did you undergo puberty? \_\_\_\_\_ years  
*(defined for girls as the age of their first period and for boys as the appearance of multiple pubic hairs)*
5. At what approximate age do you think you reached the end of puberty? \_\_\_\_\_ years
6. At what age did you have your first menarche? *(for women only)* \_\_\_\_\_ years
7. At what age did you undergo menopause? *(for women only)* \_\_\_\_\_ years

## SECTION III: Medication History

Not taking any medications

Medication	Duration of Treatment	Dosage range/day tried	Effect on Symptoms [increase (↑, ↑↑, ↑↑↑) no change (↔) decrease (↓, ↓↓, ↓↓↓)]				
			Excessive Daytime Sleepiness	Disturbed Nocturnal Sleep	Muscle Weakness (Cataplexy) With Emotions	Hypnagogic Hallucinations When Falling Asleep	Sleep Paralysis Falling Asleep or Awakening
<b>Sodium-Oxybate</b> ( <i>Xyrem</i> )	Day(s) <input type="checkbox"/> Week(s) <input type="checkbox"/> Month(s) <input type="checkbox"/> Year(s) <input type="checkbox"/>						
<b>NON-TRICYCLIC ANTI-CATAPLECTICS</b>							
<b>Citalopram</b> ( <i>Celexa</i> )	Day(s) <input type="checkbox"/> Week(s) <input type="checkbox"/> Month(s) <input type="checkbox"/> Year(s) <input type="checkbox"/>						
<b>Fluvoxamine</b> ( <i>Luvox</i> )	Day(s) <input type="checkbox"/> Week(s) <input type="checkbox"/> Month(s) <input type="checkbox"/> Year(s) <input type="checkbox"/>						
<b>Paroxetine</b> ( <i>Paxil</i> )	Day(s) <input type="checkbox"/> Week(s) <input type="checkbox"/> Month(s) <input type="checkbox"/> Year(s) <input type="checkbox"/>						
<b>Sertraline</b> ( <i>Zoloft</i> )	Day(s) <input type="checkbox"/> Week(s) <input type="checkbox"/> Month(s) <input type="checkbox"/> Year(s) <input type="checkbox"/>						
<b>Fluoxetine</b> ( <i>Prozac</i> )	Day(s) <input type="checkbox"/> Week(s) <input type="checkbox"/> Month(s) <input type="checkbox"/> Year(s) <input type="checkbox"/>						
<b>Escitalopram</b> ( <i>Lexapro</i> )	Day(s) <input type="checkbox"/> Week(s) <input type="checkbox"/> Month(s) <input type="checkbox"/> Year(s) <input type="checkbox"/>						
<b>Atomoxetine</b> ( <i>Strattera</i> )	Day(s) <input type="checkbox"/> Week(s) <input type="checkbox"/> Month(s) <input type="checkbox"/> Year(s) <input type="checkbox"/>						
<b>Venlafaxine</b> ( <i>Effexor</i> ) <input type="checkbox"/> Regular <input type="checkbox"/> XR / SR	Day(s) <input type="checkbox"/> Week(s) <input type="checkbox"/> Month(s) <input type="checkbox"/> Year(s) <input type="checkbox"/>						
<b>TRICYCLIC ANTI-CATAPLECTICS</b>							
<b>Imipramine</b> ( <i>Janimine, Tofranil</i> )	Day(s) <input type="checkbox"/> Week(s) <input type="checkbox"/> Month(s) <input type="checkbox"/> Year(s) <input type="checkbox"/>						
<b>Chlomipramine</b> ( <i>Anafranil</i> )	Day(s) <input type="checkbox"/> Week(s) <input type="checkbox"/> Month(s) <input type="checkbox"/> Year(s) <input type="checkbox"/>						
<b>Protriptyline</b> ( <i>Vicartil</i> )	Day(s) <input type="checkbox"/> Week(s) <input type="checkbox"/> Month(s) <input type="checkbox"/> Year(s) <input type="checkbox"/>						
<b>Desipramine</b> ( <i>Desyrel</i> )	Day(s) <input type="checkbox"/> Week(s) <input type="checkbox"/> Month(s) <input type="checkbox"/> Year(s) <input type="checkbox"/>						
<b>STIMULANTS</b>							
<b>Modafinil</b> ( <i>Provigil</i> )	Day(s) <input type="checkbox"/> Week(s) <input type="checkbox"/> Month(s) <input type="checkbox"/> Year(s) <input type="checkbox"/>						
<b>Methylphenidate</b> ( <i>Ritalin</i> ) <input type="checkbox"/> Regular <input type="checkbox"/> XR / SR	Day(s) <input type="checkbox"/> Week(s) <input type="checkbox"/> Month(s) <input type="checkbox"/> Year(s) <input type="checkbox"/>						
<b>Dextroamphetamine</b> ( <i>Dexedrine</i> ) <input type="checkbox"/> Regular <input type="checkbox"/> XR / SR	Day(s) <input type="checkbox"/> Week(s) <input type="checkbox"/> Month(s) <input type="checkbox"/> Year(s) <input type="checkbox"/>						
<b>Methamphetamine</b> ( <i>Desoxyn</i> )	Day(s) <input type="checkbox"/> Week(s) <input type="checkbox"/> Month(s) <input type="checkbox"/> Year(s) <input type="checkbox"/>						
<b>D-L Amphetamine Salts</b> ( <i>Adderal</i> ) <input type="checkbox"/> Regular <input type="checkbox"/> XR / SR / CD / LA	Day(s) <input type="checkbox"/> Week(s) <input type="checkbox"/> Month(s) <input type="checkbox"/> Year(s) <input type="checkbox"/>						
<b>Methylphenidate (D, L)</b> ( <i>Ritalin</i> )	Day(s) <input type="checkbox"/> Week(s) <input type="checkbox"/> Month(s) <input type="checkbox"/> Year(s) <input type="checkbox"/>						
<b>Methylphenidate (D, L)</b> ( <i>Concerta, Ritalin SR, Ritalin LA</i> )	Day(s) <input type="checkbox"/> Week(s) <input type="checkbox"/> Month(s) <input type="checkbox"/> Year(s) <input type="checkbox"/>						
<b>Demethylphenidate</b> ( <i>Focalin</i> )	Day(s) <input type="checkbox"/> Week(s) <input type="checkbox"/> Month(s) <input type="checkbox"/> Year(s) <input type="checkbox"/>						
<b>Methylphenidate Patch</b> ( <i>Daytrana</i> )	Day(s) <input type="checkbox"/> Week(s) <input type="checkbox"/> Month(s) <input type="checkbox"/> Year(s) <input type="checkbox"/>						
<b>Bupropion</b> ( <i>Wellbutrin</i> )	Day(s) <input type="checkbox"/> Week(s) <input type="checkbox"/> Month(s) <input type="checkbox"/> Year(s) <input type="checkbox"/>						
<b>Pemoline</b> ( <i>Cylert</i> )	Day(s) <input type="checkbox"/> Week(s) <input type="checkbox"/> Month(s) <input type="checkbox"/> Year(s) <input type="checkbox"/>						
<b>SEDATIVE HYPNOTICS</b>							
<b>Zolpidem Tartrate</b> ( <i>Ambien</i> ) <input type="checkbox"/> Regular <input type="checkbox"/> XR / SR	Day(s) <input type="checkbox"/> Week(s) <input type="checkbox"/> Month(s) <input type="checkbox"/> Year(s) <input type="checkbox"/>						
<b>Eszopiclone</b> ( <i>Lunesta</i> )	Day(s) <input type="checkbox"/> Week(s) <input type="checkbox"/> Month(s) <input type="checkbox"/> Year(s) <input type="checkbox"/>						
<b>Zaleplon</b> ( <i>Sonata</i> )	Day(s) <input type="checkbox"/> Week(s) <input type="checkbox"/> Month(s) <input type="checkbox"/> Year(s) <input type="checkbox"/>						

Medication	Duration of Treatment	Dosage range/day tried	Effect on Symptoms [increase (↑, ↑↑, ↑↑↑) no change (↔) decrease (↓, ↓↓, ↓↓↓)]				
			Excessive Daytime Sleepiness	Disturbed Nocturnal Sleep	Muscle Weakness (Cataplexy) With Emotions	Hypnagogic Hallucinations When Falling Asleep	Sleep Paralysis Falling Asleep or Awakening
<b>Trazodone</b> (Desyrel)	Day(s) <input type="checkbox"/> Week(s) <input type="checkbox"/> Month(s) <input type="checkbox"/> Year(s) <input type="checkbox"/>						
<b>Nefazodone</b> (Serzone)	Day(s) <input type="checkbox"/> Week(s) <input type="checkbox"/> Month(s) <input type="checkbox"/> Year(s) <input type="checkbox"/>						
<b>Mirtazepine</b> (Remeron)	Day(s) <input type="checkbox"/> Week(s) <input type="checkbox"/> Month(s) <input type="checkbox"/> Year(s) <input type="checkbox"/>						
<b>Other:</b>	Day(s) <input type="checkbox"/> Week(s) <input type="checkbox"/> Month(s) <input type="checkbox"/> Year(s) <input type="checkbox"/>						
<b>Other:</b>	Day(s) <input type="checkbox"/> Week(s) <input type="checkbox"/> Month(s) <input type="checkbox"/> Year(s) <input type="checkbox"/>						
<b>Other:</b>	Day(s) <input type="checkbox"/> Week(s) <input type="checkbox"/> Month(s) <input type="checkbox"/> Year(s) <input type="checkbox"/>						
<b>RESTLESS LEGS SYNDROME</b>			Leg Sensation Or Pain	Urge to Move Legs	Number of Leg Kicks At Night	Length of Time It Takes To Fall Asleep	Ability to Stay Asleep
<b>Pramipexole</b> (Mirapex)	Day(s) <input type="checkbox"/> Week(s) <input type="checkbox"/> Month(s) <input type="checkbox"/> Year(s) <input type="checkbox"/>						
<b>Ropinirole</b> (Requip)	Day(s) <input type="checkbox"/> Week(s) <input type="checkbox"/> Month(s) <input type="checkbox"/> Year(s) <input type="checkbox"/>						
<b>Carbidopa/levodopa</b> (Sinemet)	Day(s) <input type="checkbox"/> Week(s) <input type="checkbox"/> Month(s) <input type="checkbox"/> Year(s) <input type="checkbox"/>						
<b>Gabapentin</b> (Neurontin)	Day(s) <input type="checkbox"/> Week(s) <input type="checkbox"/> Month(s) <input type="checkbox"/> Year(s) <input type="checkbox"/>						
<b>Opioids</b> (list brand/type)	Day(s) <input type="checkbox"/> Week(s) <input type="checkbox"/> Month(s) <input type="checkbox"/> Year(s) <input type="checkbox"/>						
<b>Other:</b>	Day(s) <input type="checkbox"/> Week(s) <input type="checkbox"/> Month(s) <input type="checkbox"/> Year(s) <input type="checkbox"/>						
<b>Other:</b>	Day(s) <input type="checkbox"/> Week(s) <input type="checkbox"/> Month(s) <input type="checkbox"/> Year(s) <input type="checkbox"/>						
<b>Other:</b>	Day(s) <input type="checkbox"/> Week(s) <input type="checkbox"/> Month(s) <input type="checkbox"/> Year(s) <input type="checkbox"/>						

8. If any of the above medications improved a symptom and you later stopped taking them, did you experience a temporary increase, or rebound, of the symptoms?

Medication \_\_\_\_\_ Symptom \_\_\_\_\_  
 Significant rebound       Some rebound       No rebound       No return of symptoms

Medication \_\_\_\_\_ Symptom \_\_\_\_\_  
 Significant rebound       Some rebound       No rebound       No return of symptoms

Medication \_\_\_\_\_ Symptom \_\_\_\_\_  
 Significant rebound       Some rebound       No rebound       No return of symptoms

9. Do you have children?       Yes       No

10. a. If you have children, what was your medication regimen during pregnancy, if any (women only)?

\_\_\_\_\_

\_\_\_\_\_

b. If you have children, were they all born healthy? If not explain       Yes       No       N/A

\_\_\_\_\_

\_\_\_\_\_

## SECTION IV: Sleep History and Habits

If treated for any sleep disorder, remember to answer all questions as if you were untreated, unless specified otherwise.

**Sleep Studies:** Please indicate if you had each type of sleep study and when applicable, the date and location where they were performed. If you have had multiple studies, please reference the two most recent sleep studies.

Have you ever had a polysomnogram (sleep study with EEG)?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
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**SLEEP CENTER #1:** \_\_\_\_\_  
*Name of Sleep Center*

ADDRESS: \_\_\_\_\_  
*Street Address City State Zip Code Country*

TELEPHONE: (\_\_\_\_) \_\_\_\_\_ DATE OF STUDY: \_\_\_\_\_

PHYSICIAN'S NAME: \_\_\_\_\_  
Current Prescribing  
Physician?  Yes  No Physician?  Yes  No

**SLEEP CENTER #2:** \_\_\_\_\_  
*Name of Sleep Center*

ADDRESS: \_\_\_\_\_  
*Street Address City State Zip Code Country*

TELEPHONE: (\_\_\_\_) \_\_\_\_\_ DATE OF STUDY: \_\_\_\_\_

PHYSICIAN'S NAME: \_\_\_\_\_  
Current Prescribing  
Physician?  Yes  No Physician?  Yes  No

Have you ever had a Multiple Sleep Latency Test (MSLT, nap test)?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
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**SLEEP CENTER #1:** \_\_\_\_\_  
*Name of Sleep Center*

ADDRESS: \_\_\_\_\_  
*Street Address City State Zip Code Country*

TELEPHONE: (\_\_\_\_) \_\_\_\_\_ DATE OF STUDY: \_\_\_\_\_

PHYSICIAN'S NAME: \_\_\_\_\_  
Current Prescribing  
Physician?  Yes  No Physician?  Yes  No

**SLEEP CENTER #2:** \_\_\_\_\_  
*Name of Sleep Center*

ADDRESS: \_\_\_\_\_  
*Street Address City State Zip Code Country*

TELEPHONE: (\_\_\_\_) \_\_\_\_\_ DATE OF STUDY: \_\_\_\_\_

PHYSICIAN'S NAME: \_\_\_\_\_  
Current Prescribing  
Physician?  Yes  No Physician?  Yes  No

11. Are you a shift worker?  Yes  No
12. If yes, what shift do you usually work?  Day shift  Regular night shift  Rotating shifts
13. At what time do you usually get into bed on a work or school night? \_\_\_\_\_ AM / PM
14. At what time do you usually get out of bed on a work or school morning? \_\_\_\_\_ AM / PM
15. On a work or school, how long does it take you to get out of bed? \_\_\_\_\_ hr \_\_\_\_\_ min
16. Once you are out of bed on a work or school morning, how long does it take you to feel fully awake?  
\_\_\_\_\_ hr \_\_\_\_\_ min -OR-  Never feel fully awake

17. At what time do you usually get into bed on a non-work or non-school night? \_\_\_\_\_ AM / PM
18. a. At what time do you usually get out of bed on a non-work or non-school morning \_\_\_\_\_ AM / PM  
 b. On a non-work or non-school, how long does it take you to get out of bed? \_\_\_\_\_ hr \_\_\_\_\_ min
19. Once you are out of bed on a non-work or non-school morning, how long does it take you to feel fully awake? \_\_\_\_\_ hr \_\_\_\_\_ min -OR-  Never feel fully awake
20. How many hours of sleep do you think you need to feel fully rested? \_\_\_\_\_ hr \_\_\_\_\_ min  
 -OR-  Never feel fully rested
21. Do you consider yourself to be a morning person (“early bird”) or an evening person (“night owl”)?  
 Morning person  Evening person  No preference
22. How strong is your morning/evening preference?  
 Strong morning preference  Some morning preference  Strong evening preference  
 Some evening preference  No preference
23. Considering your preference, at what time would you ideally like to go to sleep? \_\_\_\_\_ AM / PM
24. Considering your preference, at what time would you ideally like to wake up? \_\_\_\_\_ AM / PM

## SECTION V: Symptoms of Insomnia

*For Section IV, please answer all questions unless directed to skip ahead. If you do shift work or otherwise have an unusual sleep/wake schedule, please consider "night" to be the time during which you normally sleep and "morning" to be your usual rising time. Likewise, "day" would be the period of time in which you are normally awake. If treated for any sleep disorder, remember to answer all questions as if you were untreated, unless specified otherwise.*

25. In general, do you sleep well at night?  Yes  No
26. How long does it usually take you to fall asleep after the lights are off? \_\_\_\_\_ hr \_\_\_\_\_ min
27. How often do you wake up too early in the morning and cannot get back to sleep?  
 Always (*every night*)  Usually (*several times/week*)  Often (*several times/month*)  
 Rarely (*several times/year*)  Never
28. How often do you feel refreshed after a typical night of sleep?  
 Always (*every night*)  Usually (*several times/week*)  Often (*several times/month*)  
 Rarely (*several times/year*)  Never
29. How often do you sleep restlessly?  
 Always (*every night*)  Usually (*several times/week*)  Often (*several times/month*)  
 Rarely (*several times/year*)  Never
30. How often do you have difficulty falling asleep at night?  
 Always (*every night*)  Usually (*several times/week*)  Often (*several times/month*)  
 Rarely (*several times/year*)  Never
31. How often do you have difficulties with maintaining sleep (waking up multiple times at night)?  
 Always (*every night*)  Usually (*several times/week*)  Often (*several times/month*)  
 Rarely (*several times/year*)  Never
32. How often do you have difficulty falling asleep **and** maintaining sleep (waking up multiple times at night)?  
 Always (*every night*)  Usually (*several times/week*)  Often (*several times/month*)  
 Rarely (*several times/year*)  Never

33. How often do you wake up during a **typical** night's sleep and have a difficult time falling back asleep? \_\_\_\_\_ times
34. If you answered more than 0 times to Question 33,
- How long does your **typical** nighttime awakening last? \_\_\_\_\_ hr \_\_\_\_\_ min
  - How long does your **longest** nighttime awakening last? \_\_\_\_\_ hr \_\_\_\_\_ min
  - At what age did you **first** begin to have this problem on a regular basis? \_\_\_\_\_ years
35. If you have difficulties with sleeping well at night (insomnia), using a scale from 0 to 10 please rate how much this problem affects you (0 = no distress/impairment; 10 = severe distress/impairment):
- In general, how much distress does this problem cause? \_\_\_\_\_
  - How much does it affect your social life/relationship with friends? \_\_\_\_\_
  - How much does it affect your relationship with your spouse/family members? \_\_\_\_\_
  - How much does it affect your relationships with your coworkers, employers teachers, or classmates? \_\_\_\_\_

## SECTION VI: Symptoms of Sleepiness

*If treated, remember to answer all questions as if you were untreated for any sleep disorder, unless specified otherwise.*

### 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 work out how they would have affected you. Use the following 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

SITUATION		CHANCE OF DOZING			
		0	1	2	3
36.	Sitting and reading	0	1	2	3
37.	Watching TV	0	1	2	3
38.	Sitting inactive in a public place (e.g., a theater or meeting)	0	1	2	3
39.	As a passenger in a car for an hour without a break	0	1	2	3
40.	Lying down to rest in the afternoon when circumstances permit	0	1	2	3
41.	Sitting and talking to someone	0	1	2	3
42.	Sitting quietly after a lunch without alcohol	0	1	2	3
43.	In a car, while stopped for a few minutes in traffic	0	1	2	3

44. How often do you have difficulty staying awake during the day?
- Once, or more, per day       Several times per week       Once per week  
 Once per month       Once per year, or less       Never
45. How often do you experience sudden sleep attacks that are so intense that you must stop what you are doing to or take a nap?
- Once, or more, per day       Several times per week       Once per week  
 Once per month       Once per year, or less       Never
46. a. Do you believe that you are sleepier than other individuals your age?       Yes       No

b. If yes, at what age did you begin to believe or become aware that you were sleepier than other individuals your age? \_\_\_\_\_ years

47. When you are very sleepy, do you ever continue your activity in a semi-automatic manner without later remembering what you have done?

- Often                       Sometimes                       Never                       Not applicable (*never sleepy*)

48. How often do you notice making more mistakes than usual in performing an activity because of sleepiness?

- Always (*every day*)                       Usually (*several times/week*)                       Often (*several times/month*)  
 Rarely (*several times/year*)                       Never                       Not applicable (*never sleepy*)

49. How often do you nap?

- Multiple times a day                       Once a day                       Several times a week  
 Several times a month                       Several times a year                       Never

50. How long does a typical nap last? \_\_\_\_\_ hr \_\_\_\_\_ min                       Not applicable (*never nap*)

51. Do you typically feel refreshed after napping?

- Always                       Sometimes                       Never                       Not applicable (*never nap*)

52. How often do you dream during your naps?

- Always                       Sometimes                       Never                       Not applicable (*never nap*)

## SECTION VII: Parasomnias

*If treated, remember to answer all questions as if you were untreated for any sleep disorder, unless specified otherwise.*

53. How often do you **currently** sleep walk?

- Always (*every night*)                       Usually (*several times/week*)                       Often (*several times/month*)  
 Rarely (*several times/year*)                       Never

54. How often did you sleep walk as **a child**?

- Always (*every night*)                       Usually (*several times/week*)                       Often (*several times/month*)  
 Rarely (*several times/year*)                       Never

55. How often do you **currently** talk in your sleep?

- Always (*every night*)                       Usually (*several times/week*)                       Often (*several times/month*)  
 Rarely (*several times/year*)                       Never

56. How often did you sleep talk as **a child**?

- Always (*every night*)                       Usually (*several times/week*)                       Often (*several times/month*)  
 Rarely (*several times/year*)                       Never

57. How often do act out your dreams?

- Always (*every night*)                       Usually (*several times/week*)                       Often (*several times/month*)  
 Rarely (*several times/year*)                       Never

58. Have you ever moved so much in your sleep that you accidentally hurt yourself or your bed partner?

- Multiple times                       Once, or a few times                       Never

## SECTION VIII: Restless Legs Syndrome and Periodic Leg Movements

If treated for any sleep disorder, remember to answer all questions as if you were untreated, unless specified otherwise.

59. How often do you experienced persistent and uncomfortable feelings or sensations in your legs while sitting or lying down?

- Always (daily)                       Usually (several times/week)                       Often (several times/month)  
 Rarely (several times/year)                       Never

60. How often do you experienced a persistent need or urge to move your legs while sitting or lying down?

- Always (daily)                       Usually (several times/week)                       Often (several times/month)  
 Rarely (several times/year)                       Never

If do not experience either of the above symptoms as described in questions 59 and 60, please skip ahead to question 64.

61. Are these uncomfortable feelings or the urge to move your legs worse in evening or at night compared with the morning?                       Yes                       No

62. Do the uncomfortable sensations in your legs or the urge to move disappear/improve when you are active or moving around?                       Yes                       No

63. How much impact do these uncomfortable sensations have on your well-being?

- Significant                       Moderate                       Minimal                       None

64. How often do you experience muscle twitches during your sleep or does your bed partner say that your muscles twitch?

- Always (every night)                       Usually (several times/week)                       Often (several times/month)  
 Rarely (several times/year)                       Never

65. How often do you kick your legs during your sleep or does your bed partner say you kick your legs?

- Always (every night)                       Usually (several times/week)                       Often (several times/month)  
 Rarely (several times/year)                       Never

## SECTION IX: Sleep Disordered Breathing / Obstructive Sleep Apnea

If treated for any sleep disorder, remember to answer all questions as if you were untreated, unless specified otherwise.

66. How often do you snore or does your bed partner say that you snore? If **NEVER**, please go to question 69.

- Always (every night)                       Usually (several times/week)                       Often (several times/month)  
 Rarely (several times/year)                       Never

67. How often, according to you or your bed partner, do you gasp, choke, make snorting sounds, or stop breathing during your sleep?

- Always (every night)                       Usually (several times/week)                       Often (several times/month)  
 Rarely (several times/year)                       Never

68. a. Are you currently being treated for sleep apnea?                       Yes                       No

b. If yes, how is it being treated?

- CPAP                       Oral Appliance                       Other: \_\_\_\_\_

## SECTION X: Hypnagogic Hallucinations

If treated for any sleep disorder, remember to answer all questions as if you were untreated, unless specified otherwise.

69. How often do you imagine feeling/seeing/hearing unusual and/or frightening people, animals, or objects, when you...

Circumstance	Never	Rarely Only a few times ever	Infrequently Less than once/month	Sometimes At least once/month, but less than once/week	Often At least once/week
a) Fall asleep abruptly?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Wake up in the morning?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Take a nap?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) Are drowsy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) Have an episode of muscle weakness?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) Wake up during the night?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If you responded "Never" to ALL of the situations in question 69 (a-f), please skip ahead to question 76.

70. Please list below the two circumstances described in question 69 (a-f) which are most frequently associated with hallucinations and provide an explanation of each.

a. \_\_\_\_\_  
*Circumstance*

Example: \_\_\_\_\_

\_\_\_\_\_

b. \_\_\_\_\_  
*Circumstance*

Example: \_\_\_\_\_

\_\_\_\_\_

71. How often do you find these hallucinations frightening?

Always

Usually

Often

Rarely

Never

72. How old were you the first time you experienced one of these hallucinations? \_\_\_\_\_ years

73. How long ago was your last hallucination?

Within the past 24 hours

Within the past week

Within the past month

Within the past year

More than a year ago

74. If you no longer experience these hallucinations, how old were you when they stopped? \_\_\_\_\_ years

75. If you no longer experience these hallucinations, please explain below why you believe they stopped  
*(example: medication, etc.)*

\_\_\_\_\_

\_\_\_\_\_

## SECTION XI: Sleep Paralysis

If treated for any sleep disorder, remember to answer all questions as if you were untreated, unless specified otherwise.

For question 76, check the box in the column that best describes the frequency at which you experience sleep paralysis in each of the following three (a-c) situations. Please check only one box per situation.

76. How often do you...

Situation	Never	Rarely <i>Only a few times ever</i>	Infrequently <i>Less than once/month</i>	Sometimes <i>At least once/month, but less than once/week</i>	Often <i>At least once/week</i>
a) Awaken in the morning and find that you are unable to move?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Awaken from a nap and find that you are unable to move?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Find that you are unable to move when falling asleep, either for the night or a nap?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If you responded "Never" to ALL of the situations in question 76 (a-c), please skip ahead to question 81.

77. If you responded yes to ANY of the situations described in question 76 (a-c), how old were you the first time you experienced these episodes of paralysis? \_\_\_\_\_ years

78. If you no longer experience these events, how old were you when they stopped? \_\_\_\_\_ years

79. If you no longer experience these events, please explain below why you believe they stopped (*example: medication, etc.*)

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80. When you awaken or fall asleep at night and find that you are unable to move (paralyzed) do you ever imagine unusual and/or frightening people, animals or objects?  Yes  No

## SECTION XII: Mood

81. A number of statements which people have used to describe themselves are given below. For each item, mark the box that indicates how frequently you agree with that statement. Please check only one box per situation.

	Never	Rarely <i>Only a few times ever</i>	Infrequently <i>Less than once/month</i>	Sometimes <i>At least once/month, but less than once/week</i>	Often <i>At least once/week</i>
a) I feel pleasant	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) I feel nervous and restless	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) I feel satisfied with myself	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) I wish I could be as happy as others seem to be	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) I feel like a failure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) I feel rested	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g) I am "calm, cool, and collected"	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	<b>Never</b>	<b>Rarely</b> <i>Only a few times ever</i>	<b>Infrequently</b> <i>Less than once/month</i>	<b>Sometimes</b> <i>At least once/month, but less than once/week</i>	<b>Often</b> <i>At least once/week</i>
h) I feel that difficulties are piling up so that I cannot overcome them	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i) I worry too much about something that doesn't really matter	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j) I am happy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k). I have disturbing thoughts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l). I lack self-confidence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
m) I feel secure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
n) I make decisions easily	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
o) I feel inadequate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
p) I am content	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
q) Some unimportant thought runs through my mind and bothers me	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
r) I take disappointments so keenly that I can't get them out of my mind	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
s) I am a steady person	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
t) I get in a state of tension as I think over recent concerns and interests	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

82. Carefully read each item in the list and indicate how much you have been bothered by the symptom during the past six months, including today. Please check only one box per situation.

	<b>Never</b>	<b>Rarely</b> <i>Only a few times ever</i>	<b>Infrequently</b> <i>Less than once/month</i>	<b>Sometimes</b> <i>At least once/month, but less than once/week</i>	<b>Often</b> <i>At least once/week</i>
a) Numbness or tingling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Feeling hot	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Wobbliness in legs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) Unable to relax	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) Fear of the worst happening	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) Dizzy or lightheaded	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g) Heart pounding/racing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h) Unsteady	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i) Terrified or afraid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j) Nervous	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k) Feeling of choking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l) Hands trembling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
m) Shaky/Unsteady	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
n) Fear of losing control	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
o) Difficulty breathing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
p) Fear of dying	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
q) Scared	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
r) Indigestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
s) Faint/Lightheaded	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
t) Face flushed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
u) Hot/Cold sweats	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

### SECTION XIII: Muscle Weakness / Cataplexy

If treated for any sleep disorder, remember to answer all questions as if you were untreated, unless specified otherwise. For question 83 check the box that best describes the frequency at which you experience cataplexy in each of the following seven (a-g) situations. Please check only one box per situation.

83. How often do you experience episodes of muscle weakness in your legs or buckling of your knees...

	<b>Never</b>	<b>Rarely</b> <i>Only a few times ever</i>	<b>Infrequently</b> <i>Less than once/month</i>	<b>Sometimes</b> <i>At least once/month, but less than once/week</i>	<b>Often</b> <i>At least once/week</i>
a) When you laugh?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) When you are angry?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) When you tell or hear a joke?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) When you are stressed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) During or after athletic activity?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) Making a quick verbal response in a playful context?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g) During sexual intercourse?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If you responded “Never” to situations **a, b and c** in question 83 (a-g), you have completed the questionnaire.

84. If you experience some type of muscle weakness in association with **any** of the situations in the previous question, please indicate which muscles can be affected. If you answer “yes,” to any of the symptoms below, please list the situations from question 83 (a-g) in which the type of muscle weakness occurs in **order of frequency**. For example, if you experience sagging or dropping of your jaw in association with laughter and athletic activities, please check the Yes box corresponding to sagging or dropping of your jaw and write “A, E” in the column labeled **Situation(s)**.

<b>Symptom</b>	<b>Yes/No</b>	<b>Situation(s)</b>
a) Sagging or dropping of your jaw?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
b) Abrupt dropping of your head and/or shoulders?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
c) Abruptly dropped objects from your hand?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
d) Felt weakness in your arms?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
e) Slurring of speech?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
f) Fallen to the ground, unable to move?	<input type="checkbox"/> Yes <input type="checkbox"/> No	

85. For each symptom below, please check the box corresponding to the response which best describes your **typical experience** during an episode of muscle weakness. During a typical episode of muscle weakness...

	<b>Always</b>	<b>Sometimes</b>	<b>Rarely</b>	<b>Never</b>	<b>Not Sure</b>
a) Can you hear?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Is your vision blurred?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Can you see?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) Do you fall asleep?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) In episodes in which you sleep, do you dream?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) Do you have time to sit or break your fall?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

86. How long does the muscle weakness typically last?

- < 5 seconds                       5– 30 seconds                       30 seconds – 2 minutes  
 2 – 10 minutes                       > 10 minutes

87. How frequently do you experience episodes of muscle weakness?

- Once, or more, per day       Several times per week       Once per week  
 Once per month       Once per year, or less       Never

88. How old were you the first time that you experienced an episode of muscle weakness? \_\_\_\_\_ years

89. If you no longer experience these events, how old were you when they stopped? \_\_\_\_\_ years

90. If you no longer experience these events, please explain below why you believe they stopped (example: medication, etc.)

---

---

### Description of First Episode of Muscle Weakness:

For questions 91-101, please complete the following questions in reference to your **FIRST** episode of muscle weakness. If you cannot remember your first episode, please select another typical instance.

91. On what date, approximately, did your FIRST episode occur? \_\_\_\_\_  
*month/day/year*

92. At what time of day did your FIRST episode occur?

- Morning       Afternoon       Evening  
 Night       Not sure

93. Where did it happen? (*Describe the situation – where were you and who were you with.*)

---

---

94. During what situation? What were you doing? (*i.e. reading, walking, meeting a friend, sitting down, watching TV, etc.*)

---

---

95. What, if anything, triggered it? Please describe and be specific. (*i.e. exercise, specific emotions, etc.*)

---

---

96. How long did the muscle weakness last?

- A few seconds       1-3 minute(s)       3-10 minutes  
 10-60 minutes       More than an hour

97. Which muscles were affected? (*check all that apply*)

- Face/Neck       Jaw/Mouth       Arms/Hands  
 Legs/Hips       Whole body

98. If your arm(s) and/or leg(s) were affected, did it concern one or both sides?

- One side       Both sides       Variable       N/A

99. Were you fully awake and conscious during the episode?       Yes       No

100. Did you have to sit down or did you fall as a result? (*If yes, briefly describe*)       Yes       No

---

---

101. Did you attempt to fight the episode weakness? (If yes, briefly describe)  Yes  No

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---

**Description of Most Recent Episode:**

For questions 102-112, please complete the following questions in reference to your **MOST RECENT** episode of muscle weakness. If you cannot remember your most recent episode, please select another typical instance.

102. On what date, approximately, did your MOST RECENT episode occur? \_\_\_\_\_  
month/day/year

103. At what time of day did your MOST RECENT episode occur?  
 Morning  Afternoon  Evening  
 Night  Not sure

104. Where did it happen? (Describe the situation – where were you and who were you with.)

---

---

105. During what situation? What were you doing? (e.g. reading, walking, meeting a friend, sitting down, watching TV, etc.)

---

---

106. What, if anything, triggered it? Please describe and be specific. (i.e. exercise, specific emotions, etc.)

---

---

107. How long did the muscle weakness last?  
 A few seconds  1-3 minutes  3-10 minutes  
 10-60 minutes  More than an hour

108. Which muscles were affected? (check all that apply)  
 Face/Neck  Jaw/Mouth  Arms/Hands  
 Legs/Hips  Whole body

109. If your arm(s) and/or leg(s) were affected did it concern one or both sides?  
 One side  Both sides  Variable  N/A

110. Were you fully awake and conscious during the episodes?  Yes  No

111. Did you have to sit down or did you fall as a result? (If yes, briefly describe)  Yes  No

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---

112. Did you attempt to fight the episode weakness? (If yes, briefly describe)  Yes  No

---

## SECTION XIV: Other Questions For Narcoleptic Patients Only

113. At what age do you think that you **definitely** had narcolepsy? \_\_\_\_\_ years

114. How abrupt was the development of your narcolepsy?

- Days                       Weeks                       Months  
 Years                       Decades                       Not yet known

115. a. Did you gain weight around the time that you developed narcolepsy?

- Yes                       No                       Not Sure

b. If yes, how much weight did you gain? \_\_\_\_\_  pounds       kilograms

116. Which, if any, of the following conditions did you experience ONE YEAR PRIOR to the onset of narcolepsy?

<u>Condition</u>	<u>Yes/No</u>	
a. Unexplained diarrhea	<input type="checkbox"/> Yes	<input type="checkbox"/> No
b. Unexplained fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No
c. Cold or cold like symptoms	<input type="checkbox"/> Yes	<input type="checkbox"/> No
d. Viral flu	<input type="checkbox"/> Yes	<input type="checkbox"/> No
e. Strep throat	<input type="checkbox"/> Yes	<input type="checkbox"/> No
f. Mononucleosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
g. Herpes	<input type="checkbox"/> Yes	<input type="checkbox"/> No
h. Food intoxication ( <i>explain below</i> )	<input type="checkbox"/> Yes	<input type="checkbox"/> No
i. Travel ( <i>explain below</i> )	<input type="checkbox"/> Yes	<input type="checkbox"/> No
j. Other ( <i>explain below</i> )	<input type="checkbox"/> Yes	<input type="checkbox"/> No

k. If you checked yes to one or more of the conditions above, please provide details in the space below (*such as the nature of head country of travel, etc.*).

---

117. How many first-degree relatives (parents, siblings, children) do you have? \_\_\_\_\_

118. How many of your first-degree relatives, if any, have narcolepsy? \_\_\_\_\_

119. How many of your first-degree relatives, if any, have narcolepsy **with** cataplexy? \_\_\_\_\_

120. a. Have you been tested for your HLA type?       Yes                       No                       Not Sure

b. If yes, was the result indicative for narcolepsy?       Yes                       No                       Not Sure

**THANK YOU!**

**Please return to the following address:**

Stanford University Center for Narcolepsy and Related Disorders (Attn: Mali Einen)  
450 Broadway Street, M/C 5704, Redwood City, CA 94063