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SLEEP CENTER _____

ADDRESS _____
street address city state/province country postal code

TELEPHONE (____) _____ DATE OF STUDY _____

Have you ever had a Multiple Sleep Latency Test (MSLT, nap test)? **YES NO**

If applicable, please indicate the location at which the MSLT was done. If you have had more than one MSLT, please complete for your two most recent MSLT's.

SLEEP CENTER _____

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TELEPHONE (____) _____ DATE OF STUDY _____

SLEEP CENTER _____

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TELEPHONE (____) _____ DATE OF STUDY _____

Have you ever been tested for your HLA type? **YES NO DON'T KNOW**

If **YES**, please indicate the physician or sleep center requesting the HLA tissue typing.

PHYSICIAN OR SLEEP CENTER _____

ADDRESS _____
street address city state/province country postal code

TELEPHONE (____) _____ DATE OF STUDY _____

Please answer the following question only if you have been diagnosed as having a sleep disorder or if you have discussed with your physician the possibility that you may have a sleep disorder.

CURRENT PHYSICIAN (physician who treats your sleep disorder and maintains your sleep disorders-related medical history and treatment records)

NAME _____ TELEPHONE (____) _____

ADDRESS _____
street address city state/province country zip code

SECTION II.

For Section II, 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 and engaged in work, school, etc.

1. Where were you born? _____
city state/province country

2. WITH WHICH OF THE FOLLOWING MAJOR ETHNIC GROUPS DO YOU IDENTIFY?
Check all that apply and specify the country or countries of origin of yourself/your forebears for each group checked. For example, if you consider yourself Asian, specify whether Chinese, Korean, etc. If you consider yourself American, specify the your family's country of origin prior to immigrating to the United States. If you are in doubt, please give your best guess and place a question mark (?) next to your answer. Please answer questions 3-10 in the same way.

- Black _____
- Caucasian _____
- Latino _____
- Asian _____
- Pacific Islander _____
- American Indian _____
- Other _____
- Unknown _____

3. Where was your **mother's mother** born? _____

4. With which of the following major ethnic groups does/did your **mother's mother** identify?
(Check all that apply and specify the country/countries of origin for each group checked.)

- Black _____
- Caucasian _____
- Latino _____
- Asian _____
- Pacific Islander _____
- American Indian _____
- Other _____
- Unknown _____

5. Where was your **mother's father** born? _____

6. With which of the following major ethnic groups does/did your **mother's father** identify?
(Check all that apply and specify the country/countries of origin for each group checked.)

- Black _____
- Caucasian _____
- Latino _____
- Asian _____
- Pacific Islander _____
- American Indian _____
- Other _____
- Unknown _____

7. Where was your **father's mother** born? _____

8. With which of the following major ethnic groups does/did your **father's mother** identify?
(Check all that apply and specify the country/countries of origin for each group checked.)

- Black _____
- Caucasian _____
- Latino _____
- Asian _____
- Pacific Islander _____
- American Indian _____
- Other _____
- Unknown _____

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9. Where was your **father's father** born? _____
10. With which of the following major ethnic groups does/did your **father's father** identify?
(Check all that apply and specify the country/countries of origin for each group checked.)

<input type="checkbox"/> Black	_____	<input type="checkbox"/> Pacific Islander	_____
<input type="checkbox"/> Caucasian	_____	<input type="checkbox"/> American Indian	_____
<input type="checkbox"/> Latino	_____	<input type="checkbox"/> Other	_____
<input type="checkbox"/> Asian	_____	<input type="checkbox"/> Unknown	_____

A. Are **both** of your parents **alive**? **YES NO**

If **YES**, would **both** of your parents be willing to submit a blood sample? **YES NO**

If **YES**, may we contact your parents? **YES NO**

Name _____

Address _____

Phone _____

SECTION III.

For each question in Section III, please circle the response that best fits you. Please do not skip any questions.

11. Do you sleep well at night? **YES NO**
12. Do you have difficulty staying awake during the day? **YES NO**

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			
13. Sitting and reading	0	1	2	3
14. Watching TV	0	1	2	3
15. Sitting inactive in a public place (e.g., a theater or meeting)	0	1	2	3
16. As a passenger in a car for an hour without a break	0	1	2	3
17. Lying down to rest in the afternoon when circumstances permit	0	1	2	3
18. Sitting and talking to someone	0	1	2	3
19. Sitting quietly after a lunch without alcohol	0	1	2	3
20. In a car, while stopped for a few minutes in traffic	0	1	2	3

SECTION IV.

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.

21. At what time do you usually get into bed at night? _____ am / pm
22. At what time do you usually get out of bed in the morning? _____ am / pm
23. How long after going to bed do you usually turn out the lights? _____ hr _____ min
24. How long does it usually take you to fall asleep after the lights are off? _____ hr _____ min
25. Have you ever had difficulty falling asleep at night? **YES NO**
26. Do you currently have difficulty falling asleep at night? **YES NO**
27. How many times do you wake up during a typical night's sleep? _____ times
If **0 times**, please go to question 29.
28. How long does your longest nighttime awakening typically last? _____ hr _____ min
29. Do you usually feel refreshed after a typical night of sleep? **YES NO**
30. Do you experience muscle twitches during your sleep? **YES NO**
31. Do your legs kick during your sleep? **YES NO**
32. Do you sweat excessively during your sleep? **YES NO**
33. Do you sleep restlessly? **YES NO**
34. Do you snore?
If **YES**, please go to question 36. **YES NO**
35. Does your bedpartner say that you snore?
If **NO**, please go to question 37. **YES NO**
36. Do you snore loudly or irregularly? **YES NO**
37. Do you or your partner notice that you sometimes stop breathing during your sleep? **YES NO**
38. Do you nap during the day? **YES NO**
39. If yes, how many times per week do you take a nap? _____ times
40. How long does a typical nap last? _____ hr _____ min
41. Do you usually feel refreshed after napping? **YES NO**

42. How often do you dream during your naps? never
 rarely
 often
 usually
 always
43. Do you believe that you are sleepier than other individuals your age? **YES** **NO**
 If **NO**, go to question 48.
44. At what age did you begin to believe or become aware that you were _____ years
 sleepier than other individuals your age?
45. Since the age you indicated in question 44 above, what would you increased
 say has happened to the severity of your sleepiness? decreased
 no change
 not sure
46. At what age was your sleepiness the **most** severe ever? _____ years
47. When was the last time that you were excessively sleepy? within the past 24 hours
 within the past week
 within the past month
 within the past year
 more than a year ago
48. Has a physician ever told you that you were excessively sleepy or **YES** **NO**
 otherwise had a problem with your sleep? If **NO**, please go to question 50.
49. If you answered **YES** to question 48, please explain.
50. Do you believe that you have **ever** been excessively sleepy or **YES** **NO**
 otherwise had a problem with your sleep?
51. If you answered **YES** to question 50 (you used to be excessively sleepy or otherwise had a
 problem with your sleep but no longer have such problems), please explain why you believe
 that you no longer have such sleep problems.

52. Listed below are medications which may be used to treat excessive sleepiness or other sleep problems. Please complete the table for all medications listed, including the effect of each medication which you have used on your excessive sleepiness. Please use the blank spaces to add any medications not listed in the table which you have used for your excessive sleepiness, or to add any medications taken for other medical conditions which have affected your excessive sleepiness.

MEDICATION	USE	USED IN	NEVER	SLEEPINESS			NO. YRS.
	<u>NOW</u>	<u>PAST</u>	<u>USED</u>	<u>decreased</u>	<u>same</u>	<u>increased</u>	<u>USED</u>
Amphetamine	_____	_____	_____	_____	_____	_____	_____
Methamphetamine (Desoxyn)	_____	_____	_____	_____	_____	_____	_____
Methylphenidate (Ritalin)	_____	_____	_____	_____	_____	_____	_____
Pemoline (Cylert)	_____	_____	_____	_____	_____	_____	_____
Clomipramine (Anafranil)	_____	_____	_____	_____	_____	_____	_____
Protriptyline (Vivactil)	_____	_____	_____	_____	_____	_____	_____
Imipramine (Tofranil)	_____	_____	_____	_____	_____	_____	_____
Desipramine (Desyrel)	_____	_____	_____	_____	_____	_____	_____
Fluoxetine (Prozac)	_____	_____	_____	_____	_____	_____	_____
Other (specify)	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____

53. If any of the above medications improved your excessive sleepiness and you later stopped taking them, please list below each discontinued medication that was helpful and reason for discontinuing.

SECTION V.

For Section V, please circle , check or fill in the correct answer to each question. Please do not skip any questions unless directed to do so.

Do you currently experience, or have you ever experienced, episodes of muscle weakness in your legs and/or buckling of your knees during the following situations?

- | | | | |
|--|------------|-----------|-----------------|
| 54. When you laugh | YES | NO | NOT SURE |
| 55. When you are angry | YES | NO | NOT SURE |
| 56. When you are excited | YES | NO | NOT SURE |
| 57. When you are surprised | YES | NO | NOT SURE |
| 58. When you remember a happy moment | YES | NO | NOT SURE |
| 59. When you remember an emotional event | YES | NO | NOT SURE |
| 60. When you are required to make a quick verbal response in a playful or funny context (e.g., a witty repartee) | YES | NO | NOT SURE |
| 61. When you are embarrassed | YES | NO | NOT SURE |
| 62. When you discipline children | YES | NO | NOT SURE |
| 63. During sexual intercourse | YES | NO | NOT SURE |
| 64. During athletic activities | YES | NO | NOT SURE |
| 65. After athletic activities | YES | NO | NOT SURE |
| 66. When you are elated | YES | NO | NOT SURE |
| 67. When you are stressed | YES | NO | NOT SURE |
| 68. When you are startled | YES | NO | NOT SURE |
| 69. When you are tense | YES | NO | NOT SURE |
| 70. While you are playing an exciting game | YES | NO | NOT SURE |
| 71. When you have a romantic thought or moment | YES | NO | NOT SURE |
| 72. When you tell or hear a joke | YES | NO | NOT SURE |
| 73. When you are moved by something emotional | YES | NO | NOT SURE |
| 74. Other (please describe) | YES | NO | NOT SURE |

If you answered **NO** to **all** of the questions above (54-74), please go to question 77.

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75. Please write in the space below the number(s) corresponding to the **two** situations from the list above (54-74) which are **most frequently** associated with muscle weakness in your legs and/or buckling of your knees. For example, if you most often experience muscle weakness in your legs or buckling of your knees when telling a joke or when surprised, please record your response as 72, 57. **Please use the same format for answering questions 76-81.**

76. Which statement best describes these episodes of muscle weakness in your legs and/or knees?

- the muscle weakness always affects **both** knees/legs
 the muscle weakness may affect **either one or both** knees/legs
 the muscle weakness always affects **only one** knee/leg

77. Have you ever experienced a sagging or dropping of your jaw during any of the above situations (54-74)? **YES NO**

If **YES**, write in the space below the number(s) corresponding to the **two** situations from the list above (54-74) which are **most frequently** associated with a sagging or dropping of your jaw.

78. Have you ever experienced an abrupt dropping of your head and/or shoulders during any of the above situations (54-74)? **YES NO**

If **YES**, write in the space below the number(s) corresponding to the **two** situations from the list above (54-74) which are **most frequently** associated with an abrupt dropping of your head and/or shoulders.

79. Have you ever abruptly dropped objects from your hand or felt weakness in your arms during any of the above situations (54-74)? **YES NO**

If **YES**, write in the space below the number(s) corresponding to the **two** situations from the list above (54-74) which are **most frequently** associated with your abruptly dropping objects or feeling a weakness in your arms.

80. Which statement best describes these episodes of muscle weakness in your hands or arms?

- the muscle weakness always affects **both** hands or arms
 the muscle weakness may affect **either one or both** hands or arms
 the muscle weakness always affects **only one** hand or arm

81. Has your speech ever become slurred during any of the above situations (54-74)? **YES NO**

If **YES**, write in the space below the number(s) corresponding to the **two** situations from the list above (54-74) which are **most frequently** associated with slurring of your speech.

82. Have you ever fallen to the ground and found yourself unable to move (paralyzed) during any of the above situations (54-74)? **YES NO**

If **YES**, write in the space below the number(s) corresponding to the **two** situations from the list above (54-74) which are **most frequently** associated with your falling to the ground and finding yourself unable to move.

83. If you responded **NO** to all of the above questions about muscle weakness (54-82), please skip to question 105. If you responded **YES** to any of the above questions (54-82), please list below the 3 situations (54-74) which are the most likely to trigger an episode of muscle weakness affecting any muscle(s) in your body and give an example of an episode of muscle weakness which you have experienced during each of these situations.

a. _____ (situation most likely to be associated with an episode of muscle weakness)
 situation

Example:

b. _____ (situation second most likely)
 situation

Example:

c. _____ (situation third most likely)
 situation

Example:

84. How long does the muscle weakness or paralysis usually last? 5 seconds-30 seconds
 30 seconds-2 minutes
 2 minutes-10 minutes
 More than 10 minutes

85. How frequently do you experience one of these episodes of muscle weakness? Once or more per day
 Several times per week
 Once per week
 Once per month
 Once per year or less

For questions 86-94, please check the response which best applies to your episodes of muscle weakness.

86. During the episodes of muscle weakness, can you hear?
 always
 sometimes
 rarely
 never
 not sure
87. During the episodes of muscle weakness, can you see?
 always
 sometimes
 rarely
 never
 not sure
88. During the episodes of muscle weakness, is your vision blurred?
 always
 sometimes
 rarely
 never
 not sure
89. During the episodes of muscle weakness, do you dream?
 always
 sometimes
 rarely
 never
 not sure
90. During the episodes of muscle weakness, do you fall asleep?
 always
 sometimes
 rarely
 never
 not sure
91. During the episodes of muscle weakness, do you lose control of your bladder (lose urine)?
 always
 sometimes
 rarely
 never
 not sure
92. During the episodes of muscle weakness, do you lose control of your bowels?
 always
 sometimes
 rarely
 never
 not sure
93. During the episodes of muscle weakness, do you faint?
 always
 sometimes
 rarely
 never
 not sure
94. During the episodes of muscle weakness, do you have time to sit down or hold onto something to break a fall?
 always
 sometimes
 rarely
 never
 not sure

95. How old were you the first time you experienced one of these episodes of muscle weakness? _____ years
96. Did the episodes of muscle weakness peak at a certain age? **YES NO**
If **NO**, please go to question 98.
97. If **YES**, at what age? _____ years
98. How long ago was your **last** episode of muscle weakness? _____
 _____ within the past 24 hours
 _____ within the past week
 _____ within the past month
 _____ within the past year
 _____ more than a year ago
99. If you no longer experience these episodes of muscle weakness, how old were you when they stopped? _____ years
100. If you no longer experience these episodes of muscle weakness, please explain why you believe that they stopped.
101. Have you ever been injured or nearly injured during an episode of muscle weakness, or have you suffered any other kind of serious consequence as a result of an episode of muscle weakness? If **YES**, please describe. **YES NO**

102. Have any of these episodes of muscle weakness ever been observed by another person? **YES NO**
- If **YES**, was it observed by a (check all that apply) _____ member of your family
 _____ friend
 _____ acquaintance
 _____ physician
 _____ stranger

If possible, please give the name, address and telephone number of three of the persons you indicated above.

NAME _____

ADDRESS _____

TELEPHONE (_____) _____ RELATIONSHIP TO YOU _____

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NAME _____

ADDRESS _____

TELEPHONE (____) _____ RELATIONSHIP TO YOU _____

NAME _____

ADDRESS _____

TELEPHONE (____) _____ RELATIONSHIP TO YOU _____

103. Listed below are medications which may be used to treat episodes of muscle weakness or other sleep problems. Please complete the table for all medications listed, including the effect of each medication which you have used on your muscle weakness. Please use the blank spaces to add any medications not listed in the table which you have used for your muscle weakness, or to add any medications taken for other medical conditions which have affected your muscle weakness.

MEDICATION	USE NOW	USED IN PAST	NEVER USED	SEVERITY OF EPISODES			NO. YRS. USED
				decreased	same	increased	
Amphetamine	_____	_____	_____	_____	_____	_____	_____
Methamphetamine (Desoxyn)	_____	_____	_____	_____	_____	_____	_____
Methylphenidate (Ritalin)	_____	_____	_____	_____	_____	_____	_____
Pemoline (Cylert)	_____	_____	_____	_____	_____	_____	_____
Clomipramine (Anafranil)	_____	_____	_____	_____	_____	_____	_____
Protriptyline (Vivactil)	_____	_____	_____	_____	_____	_____	_____
Imipramine (Tofranil)	_____	_____	_____	_____	_____	_____	_____
Desipramine (Desyrel)	_____	_____	_____	_____	_____	_____	_____
Fluoxetine (Prozac)	_____	_____	_____	_____	_____	_____	_____
Other (specify)	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____

104. If any of the above medications improved your episodes of muscle weakness and you later stopped taking them, please list below each discontinued medication that was helpful and reason for discontinuing.

SECTION VI.

For Section VI, please circle, check or fill in the correct response for each question. Please do not skip any questions unless directed to do so.

Do you currently imagine, or have you ever imagined, that you saw or heard people, animals, objects or frightening events under the following circumstances?

- | | | | |
|------|---|------------|-----------|
| 105. | When you fall asleep abruptly | YES | NO |
| 106. | When you wake up in the morning | YES | NO |
| 107. | When you wake up during the night | YES | NO |
| 108. | When you take a nap | YES | NO |
| 109. | When you are drowsy | YES | NO |
| 110. | When you have an episode of muscle weakness | YES | NO |

If you responded **NO** to **all** of the above questions (105-110), please go to question 123.

111. Please write in the space provided below the numbers corresponding to the **three** circumstances described in questions 105-110 which are most frequently associated with your experiencing this type of event, beginning with the circumstance which is most likely to be associated with this type of event, and ending with the circumstance which is least likely to be associated with such events. If you experience these events only under 1 or 2 of the circumstances described in questions 105-110, please answer accordingly.

112. Please list below the 3 circumstances you indicated in question 111 and give a typical example of one of these events which you experienced under each of the circumstances you indicated in question 111.

a. _____
circumstance

Example:

b. _____
circumstance

Example:

c. _____
circumstance

Example:

- | | | | |
|------|---|------------|-----------|
| 113. | Are these events frightening to you? | YES | NO |
| 114. | If YES , are you afraid to fall asleep again if one of these events occurs during the night? | YES | NO |

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115. How old were you the first time you experienced one of these events? _____ years

116. Did these events peak at a certain age? **YES NO**
If **NO**, please go to question 118.

117. If you responded **YES** to question 116, at what age did these events peak? _____ years

118. How long ago was your last such event? _____
 _____ within the past 24 hours
 _____ within the past week
 _____ within the past month
 _____ within the past year
 _____ more than a year ago

119. If you no longer experience these events, how old were you when they stopped? _____ years

120. If you no longer experience these events, please explain why you believe that they stopped.

121. Listed below are medications which may be used to treat sleep problems. These medications are sometimes prescribed specifically for the events described above (in which you imagine that you hear or see people, animals, objects, or frightening events). In other cases, when these medications are prescribed for sleep problems other than this type of event, patients find that the medications make these events either better or worse. Please complete the table for all medications listed, including the effect of each medication which you have used on these events. Please use the blank spaces to add any medications not listed in the table which you have used for any sleep problem, or to add any medications taken for other medical conditions which have affected these events.

MEDICATION	USE NOW	USED IN PAST	NEVER USED	SEVERITY OF EPISODES			NO. YRS. USED
				decreased	same	increased	
Amphetamine	_____	_____	_____	_____	_____	_____	_____
Methamphetamine (Desoxyn)	_____	_____	_____	_____	_____	_____	_____
Methylphenidate (Ritalin)	_____	_____	_____	_____	_____	_____	_____
Pemoline (Cylert)	_____	_____	_____	_____	_____	_____	_____
Clomipramine (Anafranil)	_____	_____	_____	_____	_____	_____	_____
Protriptyline (Vivactil)	_____	_____	_____	_____	_____	_____	_____
Imipramine (Tofranil)	_____	_____	_____	_____	_____	_____	_____
Desipramine (Desyrel)	_____	_____	_____	_____	_____	_____	_____
Fluoxetine (Prozac)	_____	_____	_____	_____	_____	_____	_____
Other (specify)	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____

122. If any of the above medications improved these events and you later stopped taking them, please list below each discontinued medication that was helpful and reason for discontinuing.

SECTION VII.

For Section VII, please circle or check the correct response for each question. Please do not skip any questions unless directed to do so.

123. Have you ever awakened in the morning and found you were unable to move (paralyzed)? **YES NO**
124. If **YES**, how often does this occur? Daily
 Several times per week
 Once per week
 Once per month
 Once per year or less
125. Have you ever awakened from a nap and found you were unable to move (paralyzed)? **YES NO**
126. If **YES**, how often does this occur? Daily
 Several times per week
 Once per week
 Once per month
 Once per year or less
127. Have you ever found that you were unable to move (paralyzed) when falling asleep, either for the night or for a nap? **YES NO**
128. If **YES**, how often does this occur? Daily
 Several times per week
 Once per week
 Once per month
 Once per year or less
129. When you awaken or fall asleep at night, do you ever imagine unusual and/or frightening people, animals or objects during one of these episodes of inability to move (paralysis)? **YES NO**
130. If you responded **YES** to **any** of the above questions (123, 125, 127 or 129), how old were you the first time you experienced this inability to move? _____ years
131. How long ago was your last such event? within the past 24 hours
 within the past week
 within the past month
 within the past year
 more than a year ago
132. If you no longer experience episodes of this inability to move, how old were you when they stopped? _____ years
133. If you no longer experience episodes of this inability to move, please explain why you believe that they stopped.

134. Listed below are medications which may be used to treat sleep problems. These medications are sometimes prescribed specifically for the episodes of inability to move described above. In other cases, when these medications are prescribed for sleep problems other than this type of event, patients find that the medications make these episodes either better or worse. Please complete the table for all medications listed, including the effect of each medication which you have used on these episodes. Please use the blank spaces to add any medications not listed in the table which you have used for any sleep problem, or to add medications taken for other medical conditions which have affected these episodes.

MEDICATION	USE	USED IN	NEVER	SEVERITY OF EPISODES			NO. YRS.
	NOW	PAST	USED	decreased	same	increased	USED
Amphetamine	_____	_____	_____	_____	_____	_____	_____
Methamphetamine (Desoxyn)	_____	_____	_____	_____	_____	_____	_____
Methylphenidate (Ritalin)	_____	_____	_____	_____	_____	_____	_____
Pemoline (Cylert)	_____	_____	_____	_____	_____	_____	_____
Clomipramine (Anafranil)	_____	_____	_____	_____	_____	_____	_____
Protriptyline (Vivactil)	_____	_____	_____	_____	_____	_____	_____
Imipramine (Tofranil)	_____	_____	_____	_____	_____	_____	_____
Desipramine (Desyrel)	_____	_____	_____	_____	_____	_____	_____
Fluoxetine (Prozac)	_____	_____	_____	_____	_____	_____	_____
Other (specify)	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____

135. If any of the above medications improved these episodes and you later stopped taking them, please list below each discontinued medication that was helpful and reason for discontinuing.

SECTION VIII.

For Section VIII, please circle, check or fill in the correct answer for each question. Please do not skip any questions unless directed to do so.

136. Do you frequently misplace objects? YES NO

137. Did you ever drive a car for a period of time and later realize that you had no memory for the intervening time (i.e., you seem to have "gone blank")? YES NO

138. If YES, at what age did you first experience such a "blank" while driving? _____ years

139. Why do you think that you "go blank" for these periods of time?

140. Did you ever "go blank" when at work, writing, working at a computer, or seated in a quiet situation? YES NO

141. If **YES**, please describe. If **NO**, please go to question 146.
142. Why do you think you "went blank" for this period of time?
143. During these "blanks", do you continue the activity in which you were involved before the "blank" began? **YES NO**
144. If **YES**, how do the "blanks" affect your performance at the activity? Worse
 Better
 No change
145. Have you ever fallen asleep during one of these "blanks?" **YES NO**

SECTION IX.

146. Please use the space below to give us feedback on any aspects of your sleep disorder that were not covered in this questionnaire.

THANK YOU

Thank you for your patience in completing this questionnaire. If any questions are unclear, please note this. You may call (800) 497-5337 if you need assistance in order to complete the questionnaire. If a postage-paid envelope has been provided, please use it to return your questionnaire to the Stanford Sleep Disorders Center, Center for Narcolepsy. If your physician gave you the questionnaire, please return it to your physician.