

NARCOLEPSY
FOLLOW-UP QUESTIONNAIRE

Please check one of the four columns for each of the numbered selections.

| | NEVER | RARELY | OFTEN | ALWAYS |
|--|-------|--------|-------|--------|
| 1. Scheduled naps are usually helpful. | _____ | _____ | _____ | _____ |
| 2. I maintain a regular bedtime. | _____ | _____ | _____ | _____ |

INDICATIONS OF ADEQUATE TREATMENT

| PROBLEMS WITH: | NEVER | WEEKLY | DAILY | MORE THAN ONCE DAILY |
|---|-------|--------|-------|-------------------------|
| 3. Sleep attacks (Sudden, irresistible need for sleep) | _____ | _____ | _____ | _____ |
| 4. Momentary paralysis of voluntary muscles (Often in association with sudden emotional reaction) | _____ | _____ | _____ | _____ |
| 5. Sleep paralysis (When falling asleep, you want to move but are unable to do so) | _____ | _____ | _____ | _____ |
| 6. Vivid, auditory or visual hallucinations or difficulty distinguishing dreams from reality | _____ | _____ | _____ | _____ |
| 7. Leg jerks, leg cramps or restless legs | _____ | _____ | _____ | _____ |
| 8. Awakening after 8 hours of sleep | _____ | _____ | _____ | _____ |
| 9. Falling asleep at night | _____ | _____ | _____ | _____ |

POSSIBLE SIDE EFFECTS FROM MEDICATIONS

| PROBLEMS WITH: | NEVER | RARELY | OFTEN | ALWAYS |
|-----------------------------------|-------|--------|-------|--------|
| 10. High blood pressure | _____ | _____ | _____ | _____ |
| 11. Headaches | _____ | _____ | _____ | _____ |
| 12. Decreased appetite | _____ | _____ | _____ | _____ |
| 13. Dry mouth | _____ | _____ | _____ | _____ |
| 14. Urinary retention | _____ | _____ | _____ | _____ |
| 15. Medications are too expensive | _____ | _____ | _____ | _____ |
| 16. Irritability | _____ | _____ | _____ | _____ |

PATIENT'S NAME

DATE

(O V E R)



Sleep Consultants, Inc.

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*Comprehensive Care of Sleep Disorders
Diagnosis, Treatment, Follow-up, Education*

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EPWORTH SLEEPINESS SCALE **NARCOLEPSY FOLLOW-UP**

Directions:

As of today, how likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? Even if you have not done some of these things recently, try to work out how they would have affected you. Please use the following scale to choose the most appropriate number for each situation:

Rating scale for chance of dozing: 0 = NEVER, 1 = SLIGHT, 2 = MODERATE, 3 = HIGH

To be completed by the patient using the above directions:

| <i>Rated Chance of Dozing</i> | <i>Situation</i> |
|-----------------------------------|--|
| _____ | Sitting and reading |
| _____ | Watching TV |
| _____ | Sitting inactive in a public place (e.g. a theater or meeting) |
| _____ | As a passenger in a car for an hour without a break |
| _____ | Lying down to rest in the afternoon when circumstances permit |
| _____ | Sitting and talking to someone |
| _____ | Sitting quietly after a lunch without alcohol |
| _____ | In a car, while stopped for a few minutes in traffic |
| _____ | Total score |

Narcolepsy is typically treated with various medications. Below are some of the more common medications; please indicate which medications you are taking, along with the dosage and how many times during the day you take them. If it is not listed, please fill in the blanks with the name and dose.

Please check those that apply:

_____ dextroamphetamine (Dexedrine)
 _____ methylphenidate (Ritalin)
 _____ methamphetamine Hcl (Desoxyn)
 _____ pemoline (Cylert)
 _____ clomipramine (Anafranil)
 _____ protriptyline (Vivactil)
 _____ fluoxetine (Prozac)
 _____ modafinil (Provigil)

Fill in dosage

_____mg
 _____mg
 _____mg
 _____mg
 _____mg
 _____mg
 _____mg
 _____mg
 _____mg

Circle number of times medication is taken per day

1 2 3 4
 1 2 3 4
 1 2 3 4
 1 2 3 4
 1 2 3 4
 1 2 3 4
 1 2 3 4
 1 2 3 4
 1 2 3 4

Patient's Name: _____

Date: _____

OVER