MADISON NEUROLOGY · NEUROLOGY SYMPTOM GUIDE

Excessive daytime sleepiness or uncontrollable sleep episodes

Structured history, interpretation & clinical review

Symptom 87 of 94
Clinical educational workbook
Version 1.0 · October 2026

Not for clinical use. This guide cannot diagnose, triage, or exclude an emergency. Seek emergency care for severe, sudden, or worsening symptoms.

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> **Document purpose**
> A structured educational history and diagnostic-reasoning workbook. Treatment is outside its scope.

Scope and safe use

Excessive daytime sleepiness is separated from fatigue by unintended sleep, sleep duration, schedule, apnea clues, cataplexy, medication, circadian timing, and safety-critical consequences.

Not for clinical use.
This educational workbook does not diagnose, triage, estimate probability, replace examination, or exclude an emergency. If a safety-screen answer is Yes or uncertain, follow the stated action rather than continuing routine interpretation.

How to complete the workbook

- Record the current episode and the person’s usual baseline; use a witness account for events with impaired awareness.
- Check one option per question unless a clinician documents a different combination. “Not sure” is unresolved information, not a negative answer.
- Complete the safety screen before all other sections. Record exact onset or last-known-well time for sudden deficits.
- Use Section 2 only after the form is complete. More than one pattern may be relevant; urgency takes precedence.
- Use Section 3 to plan focused examination and clinician-selected investigations. No test is automatic or universally required.

Specific escalation rule

New severe headache, new focal weakness or numbness, new speech/language difficulty, reduced consciousness, a prolonged seizure, severe breathing or swallowing difficulty, sudden visual loss, or rapidly progressive weakness requires emergency assessment. Call 911 in the United States.

Section 1: Input form

Checkbox history for Excessive daytime sleepiness or uncontrollable sleep episodes

1A. Immediate safety screen

Is there current severe breathlessness, blue lips, chest pain, or inability to awaken?

☐ No ☐ Yes ☐ Not sure

If Yes: Call emergency services now.

Is the person falling asleep while driving, operating machinery, or doing another safety-critical activity?

☐ No ☐ Yes ☐ Not sure

If Yes: Stop the activity now and arrange prompt assessment; do not drive until the safety issue has been evaluated.

Is there new focal weakness, sudden severe headache, confusion, or a prolonged seizure?

☐ No ☐ Yes ☐ Not sure

If Yes: Call emergency services now.

Has a sleep behavior caused serious injury, or is there a new prolonged unresponsive episode?

☐ No ☐ Yes ☐ Not sure

If Yes: Seek emergency or same-day assessment depending on current responsiveness and injury severity.

> **Stop rule:** Any Yes answer triggers the action printed under that question. Any Not sure answer requires prompt in-person clarification; do not treat it as No.

1B. Timeline

How did the symptom begin?

☐ Suddenly, over seconds or minutes ☐ Over hours to days ☐ Gradually over weeks or months ☐ Longstanding or since childhood ☐ Not sure

Use the first occurrence for recurrent episodes; use the current episode for a changing symptom.

What is the overall course?

☐ One persistent episode ☐ Separate recurrent episodes ☐ Steadily worsening ☐ Fluctuating or variable ☐ Currently resolved

Has this exact pattern been assessed before?

☐ Definitely new ☐ The same pattern occurred before ☐ Present and stable for a long time ☐ Not sure

1C. Discriminating features

Which description fits best?

☐ Unintended sleep or irresistible sleep attacks ☐ Tiredness without actually falling asleep ☐ Long unrefreshing sleep with difficulty awakening ☐ Variable sleepiness

How much regular sleep opportunity is there?

☐ Usually insufficient time for sleep ☐ Adequate time but still sleepy ☐ Highly irregular shift/circadian schedule ☐ Not sure

Are there witnessed apneas, snoring, cataplexy, sleep paralysis, or dream-like hallucinations?

☐ Snoring, gasping, or witnessed pauses ☐ Emotion-triggered weakness, paralysis, or hallucinations ☐ Both groups ☐ None

Is there a sedating medicine/substance, neurological illness, mood disorder, or another sleep disorder?

☐ Yes ☐ No known contributor ☐ Not sure

1D. Associated findings

Are there other neurological symptoms—weakness, numbness, speech change, double vision, swallowing difficulty, or severe imbalance?

☐ Yes ☐ No ☐ Not sure

Are there systemic clues—fever, weight loss, cancer, infection risk, pregnancy/postpartum status, or a new medication?

☐ Yes ☐ No ☐ Not sure

How much does this affect daily activity?

☐ Noticeable but activities continue ☐ Some activities are limited ☐ Cannot perform usual activities ☐ Not sure

1E. Clinical context

Who is being assessed?

☐ Adult or adolescent ☐ Child under 12 ☐ Adult aged 65 or older

Could a medicine, substance, withdrawal, or recent dose change be relevant?

☐ No plausible contributor ☐ Yes or possibly ☐ Not reviewed

Include sedatives, dopamine-blocking drugs, stimulants, decongestants, anticholinergics, alcohol, and non-prescribed substances when relevant.

Is there a relevant neurological, muscular, metabolic, cardiovascular, autoimmune, or sleep disorder?

☐ No known relevant condition ☐ Yes ☐ Not sure

What prior information is available?

☐ A previous examination or investigation ☐ Prior records but no clear explanation ☐ No useful prior assessment ☐ Not sure

Additional history and documentation

Record exact dates/times, witness details, relevant medication doses and changes, prior investigation reports, and the person's baseline function.

Section 2: Interpreting the input form

Answer combinations generate a differential and an assessment pathway—not a diagnosis.

> **Precedence:** Emergency safety answers override every pattern below. Otherwise, the highest-urgency fully matched pattern takes precedence. If entries are incomplete, contradictory, or match no pattern, use the unresolved-information pathway.

Pattern 1: Central hypersomnolence pattern

Are there witnessed apneas, snoring, cataplexy, sleep paralysis, or dream-like hallucinations? Emotion-triggered weakness, paralysis, or hallucinations
Which description fits best? Unintended sleep or irresistible sleep attacks / Long unrefreshing sleep with difficulty awakening

Prompt clinical review pattern — Promptly

Sleep attacks or prolonged unrefreshing sleep with narcolepsy-associated features needs specialist sleep assessment.

Differential to review:

- Narcolepsy, idiopathic hypersomnia, or central hypersomnolence

Action: Arrange an in-person medical or neurological review promptly, usually within days. Seek sooner care if the pattern changes.

Pattern 2: Sleep-apnea pattern

Are there witnessed apneas, snoring, cataplexy, sleep paralysis, or dream-like hallucinations? Snoring, gasping, or witnessed pauses / Both groups

Prompt clinical review pattern — Promptly

Sleepiness with snoring, gasping, or witnessed pauses follows a sleep-apnea testing pathway.

Differential to review:

- Obstructive sleep apnea or another sleep-related breathing disorder

Action: Arrange an in-person medical or neurological review promptly, usually within days. Seek sooner care if the pattern changes.

Pattern 3: Insufficient or irregular sleep pattern

How much regular sleep opportunity is there? Usually insufficient time for sleep / Highly irregular shift/circadian schedule

Structured clinical review pattern — Routine review

Short or irregular sleep opportunity is assessed before labeling a central hypersomnolence.

Differential to review:

- Insufficient sleep or circadian rhythm disorder
- Obstructive sleep apnea or another sleep-related breathing disorder

Action: Arrange a routine in-person clinical review. New, severe, or worsening symptoms change this pathway.

Pattern 4: Medication or non-sleep fatigue pattern

Is there a sedating medicine/substance, neurological illness, mood disorder, or another sleep disorder? Yes
Which description fits best? Tiredness without actually falling asleep

Structured clinical review pattern — Routine review

Tiredness without unintended sleep and a plausible contributor calls for broader medical and medication review.

Differential to review:

- Medication, medical, neurological, psychiatric, or fatigue-related cause

Action: Arrange a routine in-person clinical review. New, severe, or worsening symptoms change this pathway.

Unresolved-information pathway: The entries need structured in-person characterization.

Prompt clinical review pattern — Promptly

Do not guess missing answers or convert uncertainty into reassurance. Document what is unknown, perform an in-person examination, clarify the timeline with a witness or records when available, and reassess if any new feature appears.

Action: Arrange an in-person medical or neurological review promptly, usually within days. Seek sooner care if the pattern changes.

Section 3: Clinical review

Diagnostic modules and focused investigation logic

The examination comes before a test list. Select investigations only after localization, urgency, comorbidity, pregnancy status, renal function, anticoagulation, and prior results have been considered.

3.1 Insufficient sleep or circadian rhythm disorder

Discriminating features: Short or irregular sleep opportunity with sleepiness that tracks schedule and catch-up sleep.

Logical investigations: Sleep diary and schedule review; actigraphy or specialist assessment when pattern remains unclear.

3.2 Obstructive sleep apnea or another sleep-related breathing disorder

Discriminating features: Snoring, witnessed pauses, gasping, morning headache, or resistant sleepiness despite adequate sleep time.

Logical investigations: Clinical sleep assessment and appropriate sleep-apnea testing; safety-critical sleepiness needs prompt action.

3.3 Narcolepsy, idiopathic hypersomnia, or central hypersomnolence

Discriminating features: Irresistible sleep, cataplexy, sleep paralysis/hallucinations, or long unrefreshing sleep without another explanation.

Logical investigations: Sleep-specialist assessment with polysomnography and multiple sleep-latency testing when indicated.

3.4 Medication, medical, neurological, psychiatric, or fatigue-related cause

Discriminating features: Sedatives, systemic disease, mood symptoms, brain disease, or tiredness without actual sleep.

Logical investigations: Medication, medical, mood, and neurological review; distinguish sleep propensity from fatigue.

Reassessment and documentation

- If the symptom pattern changes, repeat the safety screen and timeline rather than carrying forward an earlier interpretation.
- If a test is unrevealing but the deficit persists or progresses, revisit localization and seek specialist review; a normal result does not automatically end assessment.
- If symptoms resolve, document duration, completeness of recovery, recurrence, and any residual deficit. Resolved sudden focal symptoms can still require urgent vascular assessment.
- If the history and examination conflict, obtain collateral information and in-person review rather than forcing a single diagnostic label.

Selected references

Sources provide background standards and do not replace local emergency pathways or current specialist guidance. Accessed October 2026.

1. National Institute for Health and Care Excellence. (2021, updated 2024). *Obstructive sleep apnoea/hypopnoea syndrome and obesity hypoventilation syndrome in over 16s (NG202)*. https://www.nice.org.uk/guidance/ng202
2. Winkelman JW, Berkowski JA, DelRosso LM, et al.. (2025). *Treatment of restless legs syndrome and periodic limb movement disorder: an American Academy of Sleep Medicine clinical practice guideline*. https://pubmed.ncbi.nlm.nih.gov/39324694/

Madison Neurology LLC — Neurology Symptom Guide
Excessive daytime sleepiness or uncontrollable sleep episodes
Educational reference only. Not for clinical use. Treatment is outside the scope of this workbook.