Parham Gharagozlou, M.D.
Sleep and Neuropharmacology

office@healthysleepcare.com
Tel: (925) 849 6634
Fax: (925) 849 6635
3108 Willow Pass Road,
Concord, CA 94519

Intake questionnaire

Name: Sex: male / female

Date of Birth: Date:

Your patience with filling this form will help me to answer your questions instead of gathering the following information at the time of visiting with you.

Day-Night Cycle

During weekdays when do you generally go to bed to sleep?	time	….
During weekends when do you generally go to bed to sleep?		
During weekdays when do you generally get out of the bed?		
During weekends when do you generally get out of the bed?		
Do you currently shift work?	Yes	No
Generally how long does it take for you to fall asleep after going to bed?	Minutes	
Do you have long periods when you are awake in the middle of the night?	Yes	No
Do you often wake up early morning and cannot go back to sleep?	Yes	No
How many nights a week do you have poor sleep?	…..	
On a bad night how many hours of sleep do you get?	hr	
On a good night how many hours of good sleep do you get?	hr	
Generally when do you get out of the home during work days?	hr	
How many minutes do you commute to work?		…..
When do you finish your work?	time	…..
In general what time do you come home?		…..
Do you follow a regular sleep-Wake schedule on most days?	Yes	No

Breathing

Do you or your partner think that you snore? How bad?	0: none – 10 very loud	…..
Have you been told OR do you think that you gasp for air in sleep OR you have stoppage of breathing in the sleep?	Yes	No
Do you wake yourself up with an episode of loud snoring?	Yes	No

Behaviors during Sleep Period

Do you walk or talk in the sleep?	Yes	No
Do you show any behaviors while you are asleep?	Yes	No
Do you eat or drink while you are asleep?	Yes	No
Do you usually eat or drink in the middle of the night while awake?	Yes	No

Miscellaneous Symptoms

Do you have vivid dreaming?	Yes	No
Do you have sudden irresistible urge to sleep and falling asleep/dozing in inappropriate times?	Yes	No
Do you have episodes of muscle weakness after getting excited or emotional (angry, happy, etc.)?	Yes	No
Do you experience hallucination immediately before or after a sleep period?	Yes	No
Do you feel unpleasant sensations in the legs that is worse in the evenings?	Yes	No
Do you think such sensations improve if you move around?	Yes	No
Do you have messed up sheets in the bed after waking up from sleep?	Yes	No
Do you think such unpleasant sensations interfere with your sleep?	Yes	No
How long are you able to sit still before such sensations felt?	Yes	No

Excessive Daytime Sleepiness

Do you feel refreshed when you wake up?	Yes	No
How long does it take after you wake up to feel your usual self?	Yes	No
Do you often feel tired during the day?	Yes	No
Do you nap during the day? In general how many days a week? For none write 0 (0-7)	Number	….
In general how many naps do you get each day?	Number	…..
How long do you nap in average each time:	Minutes	…..

Work /School

What are your duties at work/school (mainly) Desk job Light Physical Heavy Physical

Did you have problems performing your duties at work/school?	Yes	No
Did you have problems with concentration or memory at work/school?	Yes	No
Did you have interpersonal relationship issues with colleagues/classmates?	Yes	No

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Please list your medical conditions:

What surgeries did you have in the past?

Did you have nasal injury or surgery on nose? Yes No

Please list names of your medications:

Please list name of medications you are allergic to:

Please list your other allergies:

What is the chance of dozing off or falling asleep during day performing these activities in last month: (it's ok to guess)

Activity	None	Mild	Moderate	High
Watching TV				
Sitting and Reading				
As a passenger in a car for one hour without break				
Lying down to rest in the afternoon when circumstances permit				
Sitting and talking to someone				
Sitting quietly after a lunch without alcohol				
Sitting inactive in public place like meeting or movies				
In a car, while stopped for a few minutes in traffic				

Habits

In general how many days a week do you exercise?		
In general how many minutes do you exercise each session?		
Do you smoke?	Yes	No
How much do you/did you smoke a day?		
How many years is it that you stopped smoking?	#	
How many years did you smoke?	#	
Do you drink alcohol?	Yes	No
How many alcoholic drinks you have per week?(one beer, one glass of wine or one shot of whisky is equal to one drink)		

Do you use any street drugs?		Yes	No
List the street drugs that you have used:			
How many cups of tea or coffee do you use in a day?		#	
How many soda cans/bottles do you use in a day?		#	
What is your job?			
Who lives with you at home?			
Do you use/are you supposed to use CPAP/BiLevel machine at home?		Yes	No
Do you use supplemental oxygen at home?	How much:	L/min	…..

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