

San Francisco Snoring Center

Michael R. Macdonald, M D

*Sleep well
Live well*

500 Sutter Street
Suite 430
San Francisco, CA 94102



415.956.3223

SNORING HISTORY

How old are you? _____

At what age did you begin snoring? _____

At what age did your snoring become a problem? _____

How much did you weigh five years ago? _____ Ten years ago? _____ As a teenager? _____

How tall are you? _____ feet _____ inches

What is your neck size (circumference)? _____

Who complains about your snoring? _____

How do people describe your snoring? _____

Have you been told you stop breathing while you sleep? _____

Are you a restless sleeper? _____

What time do you usually go to bed? _____

What time do you usually fall asleep? _____

What time do you usually wake up? _____

Do you wake up feeling refreshed? _____

Do you have headaches in the morning? _____

How is snoring affecting your quality of life? _____

How many nights per week do you sleep apart from your partner for all or part of the night because of your snoring? _____

How long have you slept apart because of your snoring? _____

Does anyone in your family have sleep apnea? _____