

# San Francisco Snoring Center

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*Sleep well  
Live well*

415.956.3223

## REVIEW OF SYMPTOMS

ARE YOU CURRENTLY, OR HAVE YOU HAD, PROBLEMS WITH:

### CONSTITUTIONAL

Weight Gain	YES	NO
Weight Loss	YES	NO
Night Sweats	YES	NO
Insomnia	YES	NO

### EYES

Double Vision	YES	NO
Visual Loss	YES	NO
Hearing Loss	YES	NO
Noise/Ringing in Ears	YES	NO
Nasal Congestion	YES	NO
Nasal Drainage	YES	NO
Sore Throat	YES	NO
Trouble Swallowing	YES	NO
Hoarseness	YES	NO

### CARDIOVASCULAR

Chest Pain or Angina	YES	NO
Heart Trouble	YES	NO
Rheumatic Fever	YES	NO
Heart Murmur	YES	NO
High Blood Pressure	YES	NO

### NEUROLOGICAL

Numbness	YES	NO
Weakness	YES	NO
Stroke	YES	NO
Headache	YES	NO

### ALLERGIC/IMMUNOLOGIC

Sneezing	YES	NO
Itchy Eyes/Nose	YES	NO
Itchy Throat	YES	NO
Skin Rash	YES	NO
HIV	YES	NO

### RESPIRATORY

Asthma	YES	NO
Cough Up Blood	YES	NO
TB	YES	NO
Pneumonia	YES	NO
Trouble Breathing at Night	YES	NO
Snoring	YES	NO

### GASTROINTESTINAL

Indigestion or Heartburn	YES	NO
Hepatitis	YES	NO
Jaundice	YES	NO
Blood in Stool	YES	NO
Black, Tarry Stool	YES	NO

### GENITOURINARY

Bladder Trouble	YES	NO
Prostate Disease	YES	NO
Kidney Disease		

### MUSCULOSKELETAL

Arthritis	YES	NO
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### ENDOCRINE

Diabetes	YES	NO
Thyroid Disease	YES	NO

### HEMATOLOGIC

Bleeding Disorder	YES	NO
Easy Bleeding	YES	NO

### PSYCHIATRIC

Depression	YES	NO
Other	YES	NO

The above information is accurate to the best of my knowledge

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

I have reviewed the above information with the patient.

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