San Francisco Snoring

Michael R. Macdonald, M D

500 Sutter Street
Suite 430
San Francisco, CA 94102
sleepwell@sanfranciscosnoring.com

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

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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