

Unity Sleep Disorders Center Review of Symptoms

Name: _____

DOB: _____ Date: _____

Please answer the following questions:

Constitutional:

Recent weight change.....Yes No

Eyes:

Blurred vision.....Yes No

ENT

Sinus pain/pressure.....Yes No

Nasal drainage.....Yes No

Frequent throat clearing.....Yes No

Cardiac:

Shortness of breath
(walking).....Yes No

Shortness of breath
(sleeping).....Yes No

Chest pain.....Yes No

Chest pressure.....Yes No

Swelling (legs/feet).....Yes No

Respiratory:

Cough.....Yes No

Sputum(phlegm).....Yes No

Blood.....Yes No

Wheeze.....Yes No

Gastrointestinal:

Heartburn.....Yes No

Abdominal pain.....Yes No

Nausea.....Yes No

Allergy/immunologic:

Latex.....Yes No

Environmental.....Yes No

Medication allergies.....Yes No

If yes, list medication allergies:

Psychiatric:

Anxiety.....Yes No
Mood changes.....Yes No
Depression.....Yes No

Urinary:

Blood in urine.....Yes No
Frequent urination
during day.....Yes No
Frequent urination
at night.....Yes No
Accidental evacuation
of urine.....Yes No

Skin:

Rash.....Yes No
Open wounds/
skin ulcers.....Yes No

Neurological:

Weakness.....Yes No
Frequent headaches.....Yes No

Musculoskeletal:

Joint pain.....Yes No
Joint stiffness.....Yes No

Hematologic:

Bleeding gums/nose.....Yes No

Endocrine:

Intolerant to heat.....Yes No
Intolerant to cold.....Yes No
Excessive thirst.....Yes No