



SNORING - SLEEP APNEA

Patient's Name _____ SSN _____

Mailing Address _____

City, State, Zip _____

Email Address _____

Mark any that apply:

- Snoring every night
Partner sleeps in another room due to snoring
You stop breathing during the night
Restless disturbed sleep
Headache on awakening
Feeling tired during the day
Falling asleep at work or sitting in a quiet place
Falling asleep at the wheel of a car
Irritable
Change in personality
Depression
Difficulty concentrating
Poor memory
Nasal Stuffiness
Left side
Right side
Both sides
Recent weight gain: _____ pounds in the past year

PLEASE RETURN COMPLETED FORM TO ONE OF THE FOLLOWING

Email to: zrobinson@entsavannah.com

Ear, Nose & Throat Associates of Savannah, P.C. 5201 Frederick Street Savannah, GA 31405

Fax to: 912.351.3039