



Nasal or Sinus Problems

INSTRUCTIONS: Please answer all of the questions to the best of your ability before you come to your appointment. All responses will be kept strictly confidential.

1. What is the reason for your scheduled visit?

2. Are you having pain related to this visit? Yes No

a) Location of pain: _____

b) Describe the pain: _____

c) What makes it better? _____

d) What make it worse? _____

e) How long does the pain last? _____

3. Please rate the following symptoms on a severity scale of 0 (absent) to 4 (severe):

Recurrent sinus infections	0	1	2	3	4
Facial pressure/pain	0	1	2	3	4
Nasal congestion	0	1	2	3	4
Runny nose/post-nasal drip	0	1	2	3	4
Discolored nasal discharge	0	1	2	3	4
Altered sense of smell	0	1	2	3	4

4. Do you have hay fever or other allergy symptoms? Y N
Have you ever been tested for allergies? Y N When? _____

If yes, please check your allergies:

____Dust Mite ____Cock Roach ____Mold ____Ragweed
____Grass ____Tree ____Food

Did you receive allergy shots? _____ If yes, how long? _____ Did they help? _____

5. Please rate the effectiveness of any of the following treatments that you have received (1=worst, 4= best):

Antibiotics	1	2	3	4	Never received
Antihistamines (Claritin, Allegra)	1	2	3	4	Never received
Decongestants (Sudafed)	1	2	3	4	Never received
Nasal steroid sprays (Flonase)	1	2	3	4	Never received
Oral steroids (Prednisone, Medrol)	1	2	3	4	Never received

6. Do you have RECURRENT INFECTIONS? Y N

If so, please answer the following questions:

a. To the best of your recollection, please list all the antibiotics you have taken for sinus infections, and circle the ones that have been most effective:

b. The longest period of time that you have been on a single antibiotic is:

____2 weeks or less ____2-4 weeks ____4 - 8 weeks ____More than 8 weeks

7. Do you have NASAL CONGESTION? Y N

If so, please answer the following question:

Which side is more affected? Right Left Both equally

8. Do you have FACIAL PAIN OR PRESSURE? Y N

If so, please answer the following questions:

a. On which side is your discomfort more prominent? R L Both

b. Where is your discomfort most severe? (Check all that apply)

_____ At the inner angle of the eye _____ In the cheeks

_____ Around or behind the eye _____ In the back of the head

_____ In the temple _____ On the forehead or brow

_____ Other (please describe): _____

c. Has another physician ever diagnosed you with migraines? Y N

If so, how often do you get migraines? _____

Can you distinguish your migraine headache from your sinus pain? Y N

9. Do you have NASAL DISCHARGE or POST-NASAL DRIP? Y N

If so, please check all that best describe the typical appearance of your drainage:

_____ clear _____ opaque white _____ thin _____ thick

_____ yellow _____ blood-tinged _____ green _____ other

10. Have you had any sinus imaging done? Y N

If so, check which type and list where and when it was done:

_____ X-Ray _____
_____ CT _____
_____ MRI _____