

(Patient Label)

Nasal and Sinus Symptom Questionnaire

Which of the following symptoms currently bother you? (Mark all that apply)

- | | | |
|---|---|---|
| <input type="checkbox"/> Facial pain/pressure | <input type="checkbox"/> Decreased sense of smell | |
| <input type="checkbox"/> Facial congestion/fullness | <input type="checkbox"/> Nasal discharge/pus/discholorated postnasal drainage | |
| <input type="checkbox"/> Nasal obstruction/blockage | <input type="checkbox"/> Fever | |
| <input type="checkbox"/> Headache | <input type="checkbox"/> Bad breath | <input type="checkbox"/> Cough |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Dental pain | <input type="checkbox"/> Ear pain/pressure/fullness |
| <input type="checkbox"/> Sneezing | <input type="checkbox"/> Runny nose | <input type="checkbox"/> Itchy nose |
| <input type="checkbox"/> Watery eyes | <input type="checkbox"/> Itchy eyes | <input type="checkbox"/> Itchy ears |
| <input type="checkbox"/> Dark circles under the eyes/puffy eyes | | <input type="checkbox"/> Other _____ |

The above symptoms are: Intermittent Continuous

In the list above, circle and place a "#1" next to your main complaint.

How many sinus infections have you been treated for in the last year? _____

Please name the medications have you taken for your symptoms.

Antibiotics: _____

Nasal sprays: _____

Other oral pills: _____

Claritin Clarinex Zyrtec Allegra Astelin Flonase Rhinocort Nasonex Nasocort Nasarel Atrovent

Have you ever taken oral steroids (Medrol, Prednisone)? Yes No

Have you had sinus surgery? Yes No

If so, please list the dates and what procedure(s) you were told was/were performed:

Do you have asthma? Yes No

Have you been told you have nasal/sinus polyps? Yes No

Are you allergic to/sensitive to aspirin? Yes No

Do you smoke? Yes No

Do you have environmental allergies? (e.g., hayfever, seasonal allergies, dust) Yes No

If so, have you undergone allergy testing? Yes No

Please list your sensitivities/allergies. _____

How have your allergies been treated?

 Allergy shots Yes No

 Medications Yes No

Did your environment change prior the onset of your problems? Yes No

If so, in what way? (e.g., house move, new office) _____

Are you exposed to chemicals in your occupation or have you noticed an increase in nasal or sinus symptoms around certain chemicals/aromas? Yes No

If yes, please list your sensitivities _____