(Patient Label)

Nasal and Sinus Symptom Questionnaire

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

□ Facial pain/pressure
□ Facial congestion/fullness
□ Nasal obstruction/blockage
□ Decreased sense of smell
□ Nasal discharge/pus/discolored postnasal drainage
□ Fever

□ Headache
□ Fatigue
□ Bad breath
□ Dental pain
□ Cough
□ Ear pain/pressure/fullness

□ Sneezing
□ Watery eyes
□ Dark circles under the eyes/puffy eyes
□ Runny nose
□ Itchy eyes
□ Itchy nose
□ Itchy ears
□ 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:

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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____