



*Providing Specialized Care For Your Nose and Sinuses*

**Sinus History**

(Please check all answers that apply to you -- front and back)

Name \_\_\_\_\_ DOB \_\_\_\_\_ Today's Date: \_\_\_\_\_

Worst Problem: Headache/Facial Pain \_\_\_\_ Hard Time Breathing Through Nose \_\_\_\_ Frequent Sinus Infections \_\_\_\_

When Did Symptoms First Start? Early Childhood \_\_\_\_ Teen \_\_\_\_ Adult \_\_\_\_ Since (Mo/Yr) \_\_\_\_\_

Head / Facial Pain:

How many days per month \_\_\_\_ How many hours does the usual headache last? \_\_\_\_\_  
Worse in the: Morning \_\_\_\_ Afternoon \_\_\_\_ Evening \_\_\_\_ Constant pain which gets worse \_\_\_\_  
Severity: Mild \_\_\_\_ Moderate \_\_\_\_ Severe \_\_\_\_ Quality: Dull \_\_\_\_ Sharp \_\_\_\_ Throbbing \_\_\_\_  
Location: Above the eyes \_\_\_\_ Below the eyes \_\_\_\_ Behind the eyes \_\_\_\_ Between the eyes \_\_\_\_  
Top of the head \_\_\_\_ Over the cheeks \_\_\_\_ Back of Head \_\_\_\_  
Associated Symptoms: Nausea \_\_\_\_ Tearing \_\_\_\_ Eye symptoms \_\_\_\_ Stuffy Nose \_\_\_\_  
Do your symptoms worsen with exposure to: Pressure changes \_\_\_\_ Cigarette smoke \_\_\_\_ Weather \_\_\_\_  
Perfumes \_\_\_\_ Cleaning products \_\_\_\_ Other \_\_\_\_

Hard Time Breathing Through Nose / Mouth Breathing:

Does it get worse when you lie down? Yes \_\_\_\_ No \_\_\_\_  
Which side is affected? Right \_\_\_\_ Left \_\_\_\_ Both sides \_\_\_\_ Alternating sides \_\_\_\_  
Mouth breathing: Always \_\_\_\_ Sometimes \_\_\_\_ Never \_\_\_\_ At night \_\_\_\_

Do you have problems with:

Poor Sense of Smell \_\_\_\_ Bad Breath \_\_\_\_ Frequent Sore Throat \_\_\_\_ Taste \_\_\_\_  
Frequent throat clearing \_\_\_\_ Aching teeth \_\_\_\_ Hoarseness \_\_\_\_ Cough \_\_\_\_  
Runny with your nose in the morning? Yes \_\_\_\_ No \_\_\_\_

Sinusitis:

Number of antibiotic therapies taken in last year? \_\_\_\_ Last antibiotic therapy (Mo/Yr) \_\_\_\_\_  
Relief from antibiotic therapies: Very helpful \_\_\_\_ Somewhat helpful \_\_\_\_ Not very helpful \_\_\_\_  
Side effects from antibiotics: None \_\_\_\_ Allergies \_\_\_\_ Stomach problems \_\_\_\_ Yeast Infections \_\_\_\_  
List all antibiotics taken in last 12 months: \_\_\_\_\_

Drainage in Back of Throat / Runny Nose:

A lot \_\_\_\_ Somewhat \_\_\_\_ Not much \_\_\_\_ Never \_\_\_\_  
Color: Green \_\_\_\_ Yellow \_\_\_\_ White \_\_\_\_ Clear \_\_\_\_

Trouble Sleeping: None \_\_\_\_ Snoring \_\_\_\_ Apnea \_\_\_\_ Energy Level: Normal \_\_\_\_ Low \_\_\_\_

Do You Think Your Symptoms Are? Progressive \_\_\_\_ Stable \_\_\_\_ Affecting quality of life: Yes \_\_\_\_ No \_\_\_\_

Do you miss work or school due to sinus disease? Yes \_\_\_\_ No \_\_\_\_ Average number of days missed per year \_\_\_\_

Do your sinus or nasal problems affect your life every day? Yes \_\_\_\_ No \_\_\_\_

Do you think you have: Allergies \_\_\_\_ Asthma \_\_\_\_ Eczema \_\_\_\_ Hives \_\_\_\_ Migraines \_\_\_\_

Have you been tested for allergies? Yes \_\_\_\_ No \_\_\_\_ If yes, by whom and when \_\_\_\_\_  
Ever take allergy shots? Yes \_\_\_\_ No \_\_\_\_ If yes, how long? \_\_\_\_\_ Did the shots help? Yes \_\_\_\_ No \_\_\_\_

Do you use: Over the counter nose sprays (Vicks™, Afrin™, Duration™, or others) Yes \_\_\_ No \_\_\_  
 Over the counter antihistamines (Benadryl™, Tavist™, others) Yes \_\_\_ No \_\_\_

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Prescription antihistamines: Yes \_\_\_ No \_\_\_ Check all that apply: Hismanal\_\_ Claritin\_\_ Allegra\_\_ Zyrtec\_\_ Astelin™\_\_

Prescription nose sprays: Yes \_\_\_ No \_\_\_ Please list: \_\_\_\_\_

Saline irrigations: Yes \_\_\_ No \_\_\_

Have you had: Sinus x-rays Yes \_\_\_ No \_\_\_ Results: Normal \_\_\_ Abnormal \_\_\_  
 CT Scans Yes \_\_\_ No \_\_\_ Results: Normal \_\_\_ Abnormal \_\_\_ Where: \_\_\_\_\_

Operations: Nasal septal (breathing) surgery: Yes \_\_\_ No \_\_\_ When / Dr. Name? \_\_\_\_\_ / \_\_\_\_\_  
 Relief from surgery: Yes \_\_\_ No \_\_\_ A little \_\_\_  
 Sinus surgery: Yes \_\_\_ No \_\_\_ When? \_\_\_\_\_  
 Relief from surgery: Yes \_\_\_ No \_\_\_ A little \_\_\_

Do you feel you are miserable with sinus problems? Yes \_\_\_ No \_\_\_

Do you feel you have received enough medicines for your sinus problems? Yes \_\_\_ No \_\_\_

Have you or any one of your family experienced problems with surgical bleeding or anesthesia? Yes \_\_\_ No \_\_\_

If so, explain: \_\_\_\_\_

### SYMPTOM HISTORY

Grade each symptom from 1-10 with 10 being the worst and 0 for not present

<b>Blockage of Nasal Breathing</b>		<b>Eye Pain / Pressure</b>	
<b>Snoring</b>		<b>Throat Pain / Pressure</b>	
<b>Runny Nose</b>		<b>Ear Pain / Pressure</b>	
<b>Frequent Throat Clearing</b>		<b>Hoarseness</b>	
<b>Chronic Cough</b>		<b>Itchy Eyes</b>	
<b>Bad Breath</b>		<b>Sneezing</b>	
<b>Postnasal Drainage</b>		<b>Watery Eyes</b>	
<b>Facial Pain / Pressure</b>		<b>Scratchy Throat</b>	
<b>Head Pain / Pressure</b>		<b>Red Eyes</b>	
<b>Teeth Pain / Aching</b>		<b>Puffy Eyes</b>	
		<b>General Fatigue</b>	

What single problem with your nose and sinuses bothers you most?

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1/2006