



Name: _____

DOB: _____ Date: _____ EMR#: _____

Nasal & Sinus Questionnaire

1. Do you often have nasal congestion, stuffiness, mouth breathing or obstructed nasal breathing passages? **Circle one: Yes/No**

- a. If so, left, right or both sides? _____
- b. All the time, most of the time, sometimes, occasionally or rarely? _____
- c. Are you aware of the problem every day to some degree? _____
- d. Is it worse when you lie down? **Circle one: Yes/No**
- e. Can rolling to one side help open up the obstruction? **Circle one: Yes/No**
- f. Do you use anything to help this problem? Please list what, how often and how much it helps:

- g. Do you know of anything that makes these symptoms worse? **Circle one: Yes/No**
If Yes, please list: _____
- h. How would you rate the overall severity of your nasal obstruction?
_____ Mild _____ Moderate _____ Severe

2. Do you experience symptoms of sneezing, itchy eyes, clear runny nose? **Circle one: Yes/No**

- a. _____ All the time _____ most of the time _____ sometimes _____ occasionally _____ rarely
- b. What have you taken for these symptoms? _____
- c. Has it helped? **Circle one: Yes/No**
- d. Have you been tested for allergy? **Circle one: Yes/No** **If Yes, when and by whom?**
Date: _____ By whom? _____
Results: _____
- e. Are you now or have you been on allergy shots? **Circle one: Yes/No**
By whom? _____

3. Do you develop sinus infections?

(We are referring to episodes lasting at least a week, or until antibiotics are started. Symptoms include face pressure or pain, yellow or green nasal drainage that is often accompanied by upper toothache, cough and thick post-nasal drainage.) **Circle one: Yes/No**

- a. If so, how long do they typically last? _____ days/weeks (Please circle one.)
- b. If so, how many infections have you had in the past 12 months? _____
- c. How would you rate the severity of your infections?
_____ Mild _____ Moderate _____ Severe
- d. Do you have these symptoms to some degree all the time? **Circle one: Yes/No**



e. What treatment have you had for these in the last year? (Please include name of antibiotics, prescriptions and over-the-counter medicines used in the past 12 months.)

Name of Antibiotic: _____ # of times: _____
Name of Antibiotic: _____ # of times: _____
Name of Antibiotic: _____ # of times: _____
Name of Antibiotic: _____ # of times: _____
Other Medicines: _____

f. Have you ever had a complication from these infections such as hospitalization, pneumonia, asthma attack or infection spreading to your eye or brain?

Circle one: Yes/No **If yes, please list:** _____

4. Have you ever had nasal surgery, sinus surgery or facial fractures before? **Circle one: Yes/No**
If so, please describe, including approximate date: _____
5. Do you or family members have a history of nasal polyps? **Circle one: Yes/No**
6. Do you have a sensitivity or allergy to aspirin? **Circle one: Yes/No**
7. If your problems could be remedied with a 60 minute procedure which included no packing, splints, or black eyes, and generally allowed you to return to normal activity within 3-7 days, would you want to learn more about it? **Circle one: Yes/No**