Name:_____ **Date of Birth:** _____/_____/_____

NASAL & SINUS QUESTIONNAIRE

Dr. Samuel O. Antony, M.D.

Which of the following symptoms currently bother you? (Please mark **ALL** that apply)

____ Facial pain/ Pressure How long? _____

____ Decreased sense of smell How long? _____ Severity_____

____ Facial congestion/ Fullness/ Pressure How long? _____

____ Nasal discharge/ discolored drainage Color/ Thickness _____

____ Nasal obstruction/ blockage RIGHT or LEFT side? (Please circle)

____ Fever Highest temperature _____ How long? _____

____ Headache Location _____ Severity?_____

____ Sneezing/ Runny nose How long? _____

____ Ear pain/ Pressure RIGHT or LEFT side? (Please circle)

____ Decreased in hearing How long?_____ How long? _____

The above symptoms are: CONTINUOUS _____ or INTERMITTENT _____

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

** Please name the MEDICATIONS you have taken for your symptoms.

- Antibiotics _____

How long? _____ Results? _____

How many rounds of antibiotics have you taken? _____

- Nasal Sprays? _____

How long? _____ Results? _____

OTHER medications? (E.G.: Antihistamines, Decongestants, ETC...) _____

_____

Name: _____ **Date of Birth:** _____/_____/_____

Have you used NASAL SALINE IRRIGATION?_____ Results? _____

Have you had sinus surgery? YES _____ or NO _____

Have you been told you have nasal/ sinus polyps? YES_____ or NO _____

Do you have ENVIRONMENTAL ALLERGIES? YES _____ or NO _____

Have you been allergy tested? YES _____ NO_____ DATE _____/_____/_____

Please list your sensitivities/ allergies: _____

_____.

Did your environment change prior to the onset of your problems? _____

If so, in what way? _____

Have you had any previous testing? YES _____ NO_____

CT scan- date: _____ Location: _____

MRI - date: _____ Location: _____

Other- date: _____ Location: _____

***NURSE REVIEW _____