

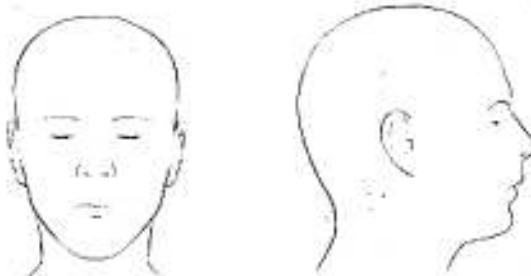
QUESTIONNAIRE FOR NEW SINUS PATIENTS

NAME _____ TODAY'S DATE _____

DOB _____ PRESENT AGE _____

MALE/FEMALE _____

1. Who diagnosed you with sinus problems?
 Self diagnosed
 Family Physician or other health-care professional (nurse, etc)
2. What is your most bothersome symptom? Please check **one** only.
 Can't breathe through nose Facial Swelling
 Headaches/Facial pain General Tiredness
 Runny nose Postnasal drip
3. What other symptoms do you have? Check all that apply.
 Can't breathe through nose Facial Swelling
 Headaches/Facial pain General Tiredness
 Runny nose Postnasal drip
4. If one of your symptoms is headache or facial pain, please indicate on the drawing below where you experience this pain.



5. How long have you had symptoms of sinusitis?
 Less than one month Between one and six months
 Six months to two years More than two years
6. Are your symptoms present
 Only occasionally Only in certain seasons
 All of the time
7. What medicines have you tried (over-the-counter or prescription)?
 Antibiotics, please list _____
 Non-prescription "cold and sinus" preparations
 Nasal decongestant sprays or drops (Afrin, etc.)
 Nasal steroid sprays (Flonase, Nasonex, Nasacort, etc.)
 Other medicines _____
8. Which of these has worked the best?

9. Have you had:
 Sinus X-Rays
 Sinus CT Scans
 Sinus surgery

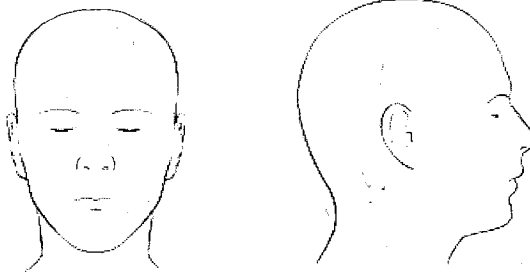
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PLEASE PLACE AN X ON YES OR NO AS IT APPLIES AND FILL IN THE BLANK SPACES.

1. Please describe your main symptoms: _____

2. How long have you had your symptoms? _____

3. How many sinus infections do you have per year? _____

YES	NO	
_____	_____	Do you have nasal congestion or blockage?
_____	_____	Is your congestion or blockage predominantly on one side?
_____	_____	If yes, which side? _____ Right _____ Left
_____	_____	Do you have Post Nasal drainage? (Drainage from the nose towards the back of the throat)
_____	_____	If so is this drainage _____ Clear _____ Thick _____ Yellowish or Green
_____	_____	Do you have a frequent runny nose?
_____	_____	If so is this drainage _____ Clear _____ Thick _____ Yellowish or Green
_____	_____	Do you have a lot of facial pressure or fullness over your sinuses?
_____	_____	Do you have fullness or pressure or pain when leaning over?
_____	_____	Do you have pain with one side worse than the other?
_____	_____	If so which one? _____ Right _____ Left
_____	_____	Do you have aching or pressure which is a steady or constant ache?
_____	_____	Do you have a pounding-type pain?
_____	_____	Have aspirin or Motrin ever caused you to have wheezing or rashes?
_____	_____	Have you had a significant nasal trauma which you feel may have caused some of your problem?
_____	_____	Do you use over-the-counter decongestant nasal sprays on a regular basis?
_____	_____	Do you have allergies, such as itching and sneezing, runny eyes or other hay fever-type symptoms?
_____	_____	Do you have asthma?
_____	_____	Does your nose react or is it sensitive to _____ Chemicals _____ Hair Spray _____ Perfumes _____ Temperature changes?
_____	_____	Are you exposed to a lot of chemicals or irritants at our outside work?
_____	_____	Do you have headaches which are directly related to your symptoms?
_____	_____	Do you get hoarseness when you have nasal or sinus symptoms?
_____	_____	Do you have a sore throat with your nasal or sinus symptoms?
_____	_____	Do you have wheezing or asthma attacks with your nasal or sinus symptoms?
_____	_____	Do your nasal or sinus symptoms improve significantly when you are on antibiotics?
_____	_____	Have prescription or over-the-counter medical treatment helped you in any way? If so, which medications have helped? _____
_____	_____	Have you ever had sinus surgery? If yes, please describe: _____ _____