

Name: \_\_\_\_\_ Date: \_\_\_\_\_

## Sinus Questionnaire

**History:** *Select all symptoms that you experience while having a sinus infection.*

Have you had sinus surgery before? \_\_\_\_\_ If yes, when: \_\_\_\_\_

Have you had a CT Scan of your sinuses? \_\_\_\_\_ If yes, when: \_\_\_\_\_ How many? \_\_\_\_\_

**Circle symptoms severity when you are at your WORST**

	1. Very Mild	2. Mild	3. Moderate	4. Severe	5. Very Severe
	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>
Facial Congestion/Fullness	1	2	3	4	5
Nasal Obstruction/Blockage	1	2	3	4	5
Nasal Discharge/Purulence/Discolored Postnasal Drip	1	2	3	4	5
Drainage	1	2	3	4	5
Loss of Smell	1	2	3	4	5
Fever (Acute only)	1	2	3	4	5
Pain/Pressure	1	2	3	4	5
Headache	1	2	3	4	5
Ear Pain/Pressure/Fullness	1	2	3	4	5

**Duration of Symptoms:**

How long do your symptoms last when you have a sinus infection?

- |  |   |
|--|---|
| 1. Less than 10 days                       | 3. More than 4 weeks and less than 12 weeks |
| 2. More than 10 days and less than 4 weeks | 4. More than 12 weeks                       |

How many sinus infections have you had in the last twelve months? \_\_\_\_\_

How long have you had sinus problems? \_\_\_\_\_ Months \_\_\_\_\_ Years

**History of Medical Treatment**

**Decongestants/Mucolytic/Antihistamines**

	<u>Used</u>	<u>Helped</u>		<u>Used</u>	<u>Helped</u>
Prednisone	_____	_____	Clarinet	_____	_____
Sudafed or similar over the counter medications	_____	_____	Xygal	_____	_____
Mucinex / Mucinx D	_____	_____	Astelin/Astepro	_____	_____
Claritin or Claritin D	_____	_____	Patanase	_____	_____
Allegra or Allegra D	_____	_____	Other	_____	_____
Zyrtec or Zyrtec D	_____	_____		_____	_____

**Intranasal Steroids**

	<u>Used</u>	<u>Helped</u>		<u>Used</u>	<u>Helped</u>
Veramyst	_____	_____	Nasonex	_____	_____
Flonase	_____	_____	Rhinocort Aqua	_____	_____
Nasacort AQ	_____	_____	Omnaris	_____	_____

**Antibiotics**

	How many weeks did you take it?	When did you take it last? (Date)	Did it Help? (Y/N)
Amoxicillin	_____	_____	_____
Augmentin 875	_____	_____	_____
Augmentin XR	_____	_____	_____
Bactrim DS	_____	_____	_____
Biaxin	_____	_____	_____
Ceftin	_____	_____	_____
Cefzil	_____	_____	_____
Cipro	_____	_____	_____
Clindamycin	_____	_____	_____
Levaquin 500	_____	_____	_____
Levaquin 750	_____	_____	_____
Avelox	_____	_____	_____
Omnicef	_____	_____	_____
Zithromax	_____	_____	_____
Doxycycline	_____	_____	_____
Other	_____	_____	_____

**Allergy History:**

Have you been allergy tested? Please circle YES NO If yes, when \_\_\_\_\_

What were you allergic to? \_\_\_\_\_

Symptoms	Yes	No	Symptoms	Yes	No
Sneezing	_____	_____	Nasal Itching	_____	_____
Clear Nasal Discharge	_____	_____	Decrease Smell	_____	_____
Symptoms all-year-round	_____	_____	Palate Itching	_____	_____
Symptoms are Seasonal	_____	_____	Spring _____	Fall _____	_____

**Checklist of Agents that Trigger Nasal Symptoms (check all that apply)**

Symptoms better indoors	_____	Hot Spicy Foods	_____
Symptoms better out doors	_____	Bright Lights	_____
Season (specific dates)	_____	Upper Respiratory Infections	_____
Work	_____	Contact with Pets	_____
Home	_____	Exercise	_____
Weather Variables	_____	Medications	_____
Temperature	_____	Newspaper Ink	_____
Relative Humidity	_____	Soap powder	_____
Rain/Storm	_____	Automobile Exhaust Fumes	_____
Tobacco Smoke	_____	Air pollutant	_____
Odors/Perfume	_____	Emotional Upset	_____
Alcohol Intake	_____	(particularly depression)	_____