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Patient Questionnaire for Nose or Sinus Problems

Name ______________________________ Age __________ Date ______________

Please indicate yes or no if you have the following symptoms on a regular basis.

Yes	No		Yes	No	
		Nasal Stuffiness			Aching Teeth
		Nasal Airway Obstruction			Altered Taste Sense
		Post-nasal Drainage			Loss of Taste Sense
		Runny Nose			Altered Smell Sense
		Bloody Nose			Loss of Smell Sense
		Puffy Eyes			General Fatigue
		Eye Pressure			Dizziness/Lightheadedness
		Eye Pain			Chronic Cough
		Ear Pressure			Itchy Nose
		Ear Popping			Watery Eyes
		Headaches			Red Eyes
		Facial Pressure			Scratchy Throat
		Hoarseness			Frequent Throat Clearing
		Bad Breath			Sneezing
		Sore Throat			

Rate the most bothersome three symptoms:

1.
2.
3.

Have you had any of the following?

Yes	No		Yes	No	
		Asthma			Frequent Antibiotics for Sinusitis
		Aspirin Sensitivity			Decongestant Pills
		Nasal Polyps			Decongestant Sprays or Drops
		Cystic Fibrosis			Antihistamines
		Previous Nasal or Sinus Surgery			Nasal Steroid Sprays
		Hay Fever			Nasal Injections
		Food Allergy			Oral Steroid Medication
		Family History of Allergy			Steroid Injections
		Allergy Test, If yes, Date ______________			
		Allergy Shots, If Yes, Date: From ______________ To ______________			