SINUSITIS QUESTIONNAIRE

Patient Name: ___________________________________ Account #: ______________

Date: ____________________________________________________________________

How long have you had a sinus problem? ________________________________________

Do you have trouble breathing through your nose? Yes/No Day/Night

How is your sense of smell? _________________________________________________

When was your most recent sinus infection? ____________________________________

How long did it last? _______________________________________________________

How many sinus infections have you had in the past year? _______________________

How many courses of antibiotics? ____________________________________________

How long was the course of antibiotics? ________________________________________

Current treatments/medication for your sinuses:

- Antibiotics
- Prescription sprays/nonprescription sprays
- Antihistamines/decongestants
- Irrigation
- Other: ______________________________________________________________

Past treatments/medications for your sinuses: ___________________________________

Have you been treated for polyps in your nose? _________________________________

Have you had any surgery for your nose and/or sinuses? Yes/No

If yes: What kind? _________________________________________________________

When? __________________________________________________________________

Where? __________________________________________________________________

Did it help? ______________________________________________________________

Are you sensitive to aspirin? _________________________________________________

Do you have allergies? Yes/No

If yes have they been evaluated? _____________________________________________

Do you smoke? Yes/No

Are you exposed to second hand smoke? _______________________________________

Have you ever injured your nose? _____________________________________________

Have other family members had sinus problems? Yes/No

Who and What kind? ________________________________________________________

Have you ever had a sinus CT? Yes/No

When and Where? __________________________________________________________