SINUS QUESTIONNAIRE

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NAME First___________________________ Last _______________________________
DATE / /

1. Do you think you have sinus problems? Yes No

2. If yes, for how long?

3. Do you have **Nasal Congestion** (difficulty breathing through the nose)?
Yes.
No
Yes, this is my main complaint.

5. Is this congestion/obstruction
Constant
Intermittent.

6. Which side is worse?
Right side
Left side
Both sides are stuffy.

7. For how long have you had nasal congestion/obstruction?
Less than 2 months
One year or less
Between one and two years. longer

8. Do you have **discharge** or drainage from your nose?
Yes
No.

9. Is the drainage or discharge mainly from the?
Front of nose
Back of nose
into throat (post nasal drip)
From both areas.

10. Is there a great deal of discharge?
Yes
No.

11. What if the quality of the drainage or discharge?
Watery
Tenacious(thick).

12. What is the color of the discharge?
Clear
White(opaque)
Discolored(yellow, green etc.)

13. Is your **sense of smell** Good Poor: I notice a bad smell (odor)
Yes
No

14. Are **headaches or facial pain** part of your sinus symptoms?
Yes
No
Yes, this is my main complaint.

15. How long have you had headaches/pain?
Less than 2 months
Less than 2 years
More than 2 years.
Others.

16. Where do you feel this headache/pain?
Forehead
Top of the head
Upper teeth
Inner angle of the eye,
bridge of nose
Behind eye(s).
Others.

17. How would you describe this pain?
Pressure

Throbbing
Sharp
others.

18. Does your headache/pain get worse with a cold?
Yes No
With flying?
Yes No

19. Do you have **recurrent infections**? (Worsening of normal problems)
Yes
No
Yes, this is my main complaint..

20. How many infections have you had this past year?
_____________ Last year(number)

21. What other sinus-related complaints do you have?

22. Do you have **allergies?**
Yes
No I don't know.
Have you had allergy testing? No Yes and I am allergic to______________________.

23. Have you taken allergy shots? Yes No If yes, When_________?

24. Do you or have had **asthma** or asthmatic bronchitis? Yes No.

25. What medicines do you take for asthma or bronchitis?

Please indicate the types (and names) of drugs used to treat your sinus problem.

ANTIBIOTICS Yes No *(if yes, identify below)*

AMOXACILLIN AVELOX CEFTIN AUGMENTIN SEPTRA CIPRO
LEVAQUIN TEQUIN KETEX
Other ____________________________(*specify)*

26. Have antibiotics helped
Yes
No
Temporarily or partially.

27. ANTIHISTAMINE and/or DECONGESTANT:
Yes
No

28. Have these medications helped?
Yes
No
Temporarily or partially

29. STEROID NASAL SPRAY:
Yes [Rhinocort, Nasonex, Flonase, Nasacort, Nasarel]
No

30. Have these sprays helped?
Yes
No Temporarily or partially

ORAL STEROIDS Yes [Prednisone, Medrol] No

31. Have these medications helped?
Yes
No
Temporarily or partially

32. Do you use saline or another sinus wash?
Yes
No

33. Have you had any previous nasal or sinus surgery?

Type________________________ Date_____________

Type________________________ Date_____________

34. Have you taken any alternative medicines in the past?
Homeopathy
Ayurveda
Acupressure or Acupuncture.

35. How long did you use them?
Less than 2 months
More than 2 months
More than 6 months.
Others.

36. Have any of these helped?

Yes
No
Temporarily or partially.

Consultant Notes:

Received On______________________Reviewed By___________________