

## Sino/Nasal Worksheet

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

Do you have nasal obstruction/blockage/congestion:

- Yes, which side is worse     Right     Left     Both  
 No

1. Do you have hay fever/allergies?

- Yes             No

2. Do you suspect allergies contributing to your congestion?

- Yes             No

3. Have you been tested for allergies?

- Yes, result \_\_\_\_\_             No

4. Have you ever had allergy shots (allergy immunotherapy)

- Yes, for how long? \_\_\_\_\_ Date stopped \_\_\_\_\_

Do you use steroid nasal sprays?

Name of spray: \_\_\_\_\_

- Currently \_\_\_\_\_  
 In the past \_\_\_\_\_  
 Never

Do you use other allergy medications?

Name of medications: \_\_\_\_\_

- Currently \_\_\_\_\_  
 In past \_\_\_\_\_  
 Never

How many sinus infections have you been treated for in the past year? \_\_\_\_\_

How many of these infections were treated with antibiotics?

Name of antibiotic \_\_\_\_\_

Length of treatment \_\_\_\_\_

Have you had a recent CT or MRI of your head/sinuses?

- No  
 Yes            Date \_\_\_\_\_ Location \_\_\_\_\_

Have you had prior sinus or nasal surgery?     No     Yes    Date \_\_\_\_\_ Location \_\_\_\_\_

Please check all symptoms that apply. Rate 0-10, 10 most severe. Circle your worst symptom.

- |   |  |
|---|--|
| <input type="checkbox"/> Nasal drainage _____   | <input type="checkbox"/> Sneezing _____            |
| <input type="checkbox"/> Decreased sense of smell _____   | <input type="checkbox"/> Itchy eyes or nose _____  |
| <input type="checkbox"/> Headache, location _____   | <input type="checkbox"/> Watery eyes or nose _____ |
| <input type="checkbox"/> Facial <input type="checkbox"/> pain <input type="checkbox"/> pressure _____ | <input type="checkbox"/> Postnasal drainage _____  |
| <input type="checkbox"/> Nasal bleeding ___ Right ___ Left _____                                      | <input type="checkbox"/> Coughing _____            |