INSTRUCTIONS: Please answer all of the questions to the best of your ability before you come to your appointment. All responses will be kept strictly confidential.

1. What is the reason for your scheduled visit?

______________________________________________________________________________________

What system or problem is bothering you the most?

______________________________________________________________________________________

2. Are you having pain related to this visit? No Yes
   a) Location of pain: ________________________________________________________________
   b) Describe the pain: ___________________________________________________________________
   c) What makes it better? ________________________________________________________________
   d) What makes it worse? __________________________________________________________________
   e) How long does the pain last? _________________________________________________________

3. Please rate the following symptoms on a severity scale of 0 (absent) to 4 (severe):
   Recurrent sinus infections 0 1 2 3 4
   Facial pressure/pain 0 1 2 3 4
   Nasal congestion 0 1 2 3 4
   Runny nose/post-nasal drip 0 1 2 3 4
   Discolored nasal discharge 0 1 2 3 4
   Altered sense of smell 0 1 2 3 4

4. Do you have hay fever or other allergy symptoms? Y N
   Have you ever been tested for allergies? Y N When?

______________________________________________________________________________________

If yes, please list your allergies __________________________________________________________

Did you receive allergy shots? ________ If yes, how long?_______ Did they help? ________

5. Please rate the effectiveness of any of the following treatments that you have received (1 = worst, 4 = best):
   Antibiotics 1 2 3 4 Never received
   Antihistamines (Claritin, Allegra) 1 2 3 4 Never received
   Decongestants (Sudafed) 1 2 3 4 Never received
   Nasal steroid sprays (Nasacort, Flonase, etc.) 1 2 3 4 Never received
   Oral steroids (Prednisone, Medrol) 1 2 3 4 Never received
6. **Do you have RECURRENT INFECTIONS?**  
   **Y**  **N**  
   If so, please answer the following questions:  
   a. To the best of your recollection, please list all the antibiotics you have taken for sinus infections, and circle the ones that have been most effective:  
      ___________________________________________________________________________________  
      ___________________________________________________________________________________  
   b. The longest period of time that you have been on a single antibiotic is:  
      2 weeks or less  2-4 weeks  4 - 8 weeks  More than 8 weeks  

7. **Do you have NASAL CONGESTION?**  
   **Y**  **N**  
   If so, please answer the following question:  
   Which side is more affected?  **Right**  **Left**  **Both equally**  

8. **Do you have FACIAL PAIN OR PRESSURE?**  
   **Y**  **N**  
   If so, please answer the following questions:  
   a. On which side is your discomfort more prominent?  **R**  **L**  **Both**  
   b. Where is your discomfort most severe? (Check all that apply)  
      _____ At the inner angle of the eye  _____ In the cheeks  
      _____ Around or behind the eye  _____ In the back of the head  
      _____ In the temple  _____ On the forehead or brow  
      _____ Other (please describe): __________________________________________  
   c. Has another physician ever diagnosed you with migraines?  **Y**  **N**  
      If so, how often do you get migraines? _______________________  
      Can you distinguish your migraine headache from your sinus pain?  **Y**  **N**  

9. **Do you have NASAL DISCHARGE or POST-NASAL DRIP?**  
   **Y**  **N**  
   If so, please answer the following question: Please check all that best describe the typical appearance of your drainage:  
      _____ clear  _____ opaque white  _____ thin  _____ thick  
      _____ yellow  _____ blood-tinged  _____ green  _____ other  

10. **PAST MEDICAL HISTORY**  
    Do you have or have you been treated for any of the following? (check all that apply)  
    _____ asthma  _____ heart disease  _____ high blood pressure  _____ gastritis/ulcers  
    _____ fibromyalgia  _____ stroke  _____ osteoporosis  _____ low/high thyroid  
    _____ liver disease  _____ depression  _____ immunodeficiency  _____ kidney disease  
    _____ diabetes  _____ seizures  _____ bleeding disorder  _____ cataracts  
    _____ cancer (type_________________)  _____ hepatitis (type______)  _____ glaucoma
Please list any other health problems not listed above:

______________________________________________________________________________________
______________________________________________________________________________________

11. HOSPITALIZATIONS AND OPERATIONS
Date                   Reason/Procedure                      Hospital
______________________________________________________________________________________
______________________________________________________________________________________
______________________________________________________________________________________
______________________________________________________________________________________
______________________________________________________________________________________

12. CURRENT MEDICATIONS (please include any vitamins or herbal medications)
Name                                  Dose                         Frequency
______________________________________________________________________________________
______________________________________________________________________________________
______________________________________________________________________________________
______________________________________________________________________________________
______________________________________________________________________________________
______________________________________________________________________________________

13. MEDICATION ALLERGIES
List any medication allergies and the type of reaction that occurs: (If none known, □ check here
______________________________________________________________________________________
______________________________________________________________________________________

14. FAMILY HISTORY: Please check all that apply to your family members
   ___ Allergy                             ___ Sinus disease    ___ Asthma
   ___ Cystic fibrosis                    ___ Immunodeficiency ___ Bleeding disorder
   ___ Cancer (Type and relationship of family members: _____________________________)
   ___ Other (List __________________________________)

15. SOCIAL HISTORY:
   a. Your occupation: __________________________
   b. Do you presently smoke?    Y   N   If yes, # packs per day? ___/#___ years?
   Did you ever smoke in the past?    Y   N   If yes, # packs per day? ___/#___ years?
   c. Do you drink alcohol?    Y   N   If yes, # drinks per day? ______
   d. Have you ever used any other addictive substances?   Y   N   If yes, what drug? ______
### REVIEW OF SYSTEMS

Please circle any of the health problems that pertain to you.

<table>
<thead>
<tr>
<th>Section</th>
<th>Problems</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Ears</td>
<td>Ringing, Dizziness, Drainage</td>
</tr>
<tr>
<td></td>
<td>Hearing loss, No Symptoms</td>
</tr>
<tr>
<td>b. Mouth/Throat</td>
<td>Pain or difficulty swallowing, Hoarseness</td>
</tr>
<tr>
<td></td>
<td>Lumps in Neck</td>
</tr>
<tr>
<td>c. Cardiopulmonary</td>
<td>Chest Pain, Palpitations, Shortness of breath</td>
</tr>
<tr>
<td></td>
<td>Heart murmur, Cough, No Symptoms</td>
</tr>
<tr>
<td>d. Genitourinary</td>
<td>Burning on urination, Frequency of urination</td>
</tr>
<tr>
<td></td>
<td>No Symptoms</td>
</tr>
<tr>
<td>e. Gastrointestinal</td>
<td>Heartburn, Vomiting, Diarrhea</td>
</tr>
<tr>
<td></td>
<td>Abdominal pain, No Symptoms</td>
</tr>
<tr>
<td>f. Psychological</td>
<td>Depression, No Symptoms</td>
</tr>
<tr>
<td>g. Sleep pattern</td>
<td>Snoring, Daytime sleepiness</td>
</tr>
<tr>
<td></td>
<td>Stop breathing during sleep, No Symptoms</td>
</tr>
<tr>
<td>h. Endocrine</td>
<td>Heat intolerance, Cold intolerance, Excessive thirst</td>
</tr>
<tr>
<td></td>
<td>No Symptoms</td>
</tr>
<tr>
<td>i. Eyes</td>
<td>Recent change in vision, Impaired vision</td>
</tr>
<tr>
<td></td>
<td>No Symptom</td>
</tr>
<tr>
<td>j. Neurologic</td>
<td>Weakness, Numbness, No Symptoms</td>
</tr>
<tr>
<td>k. Musculoskeletal</td>
<td>TMJ disorder, Arthritis, No Symptoms</td>
</tr>
<tr>
<td>l. General</td>
<td>Nausea, Fever, Fatigue, Weight loss, No Symptoms</td>
</tr>
<tr>
<td></td>
<td>Weight gain</td>
</tr>
<tr>
<td>m. Skin</td>
<td>Skin Cancer, No Symptoms</td>
</tr>
<tr>
<td>n. Hematologic/Lymphatic</td>
<td>Swollen Lymph Nodes</td>
</tr>
<tr>
<td>o. Allergic/Immunologic</td>
<td>Hepatitis, Frequent Infections, Immune Disorders</td>
</tr>
</tbody>
</table>

Thank you for completing this questionnaire. If you have questions about any of the above items, please ask your physician at the time of your appointment.

**Completed by:** __________________________  **Date:** ________  **Relationship to Patient:** _________

**Staff use only:**

**Reviewed by:** __________________________  **Date:** ________

**I have personally reviewed the history and review of system:**

________________________________________  **Date**

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**Attending Physician**

**Date**