



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

### Sinus Questionnaire

#### Sinus History:

- Have you had sinus surgery before? (Please circle one) Yes / No
  - If yes, when? \_\_\_\_\_
- Have you ever had a CT Scan of your sinuses? (Please circle one) Yes / No
  - If yes, when? \_\_\_\_\_

Circle all symptoms that you experience while having a sinus infection. Rate the severity based on when your symptoms are at their WORST.

	Very Mild	Mild	Moderate	Severe	Very Severe
Facial Congestion/Fullness	1	2	3	4	5
Nasal Obstruction/Blockage	1	2	3	4	5
Nasal Discharge/Purulence/Discolored Postnasal Drip	1	2	3	4	5
Loss of Smell	1	2	3	4	5
Headache	1	2	3	4	5

#### Duration of Symptoms:

How long do your symptoms last when you have a sinus infection?

- Less than 10 days
  - More than 10 days and less than 4 weeks
  - More than 4 weeks and less than 12 weeks
  - More than 12 weeks
- How many sinus infections have you had in the last twelve months? \_\_\_\_\_
  - How long have you had a sinus problem? \_\_\_\_\_ Month(s) \_\_\_\_\_ Year(s)
  - Have you been rinsing your nose with saline (salt water, netti pot, wash) (Please circle one) Yes / No
    - If yes, how long? \_\_\_\_\_



Adult and Pediatric Otolaryngology  
7777 Forest Ln, Suite B432  
Dallas, TX 75230  
Phone 972-566-8300  
Fax 972-566-8004

**History of Medical Treatment:**

**Check below any medications used- past or present.**

**Decongestants/Mucolytic/Antihistamines**

Sudafed or any similar over-the-counter medications _____	Prednisone _____	Clarinet _____
Mucinex/ Mucinex D _____	Claritin/ Claritin D _____	Xyxal _____
Allegra/ Allegra D _____	Zyrtec/ Zyrtec D _____	Astelin/Astepro _____
		Patanase _____
		Other _____

**Intranasal Steroids**

Veramyst _____	Nasonex _____
Flonase _____	Rhinocort Aqua _____
Nasocort AQ _____	Omnaris _____

**Antibiotics**

	How many weeks did you take it?	When did you take it last? (Date)
Amoxicillin _____	_____	_____
Augmentin 875 _____	_____	_____
Augmentin XR _____	_____	_____
Bactrim DS _____	_____	_____
Biaxin _____	_____	_____
Ceftin _____	_____	_____
Cefzil _____	_____	_____
Cipro _____	_____	_____
Clindamycin _____	_____	_____
Levaquin 500 _____	_____	_____
Legaquin 750 _____	_____	_____
Avelox _____	_____	_____
Omnicef _____	_____	_____
Zithromax _____	_____	_____
Doxycycline _____	_____	_____
Other _____	_____	_____



DALLAS  
ENT  
GROUP

Adult and Pediatric Otolaryngology  
7777 Forest Ln, Suite B432  
Dallas, TX 75230  
Phone 972-566-8300  
Fax 972-566-8004

**Allergy History:**

- Have you ever been allergy tested? (Please circle one) Yes / No
    - If yes, when? \_\_\_\_\_
  - What were you allergic to?
- 

Do you regularly experience any of the following symptoms? (Check all that apply)

	Yes	No		
Sneezing	_____	_____		
Clear Nasal Discharge	_____	_____		
Nasal Itching	_____	_____		
Decrease in Smell	_____	_____		
Palate Itching	_____	_____		
Symptoms are all-year-round	_____	_____		
Symptoms are seasonal	_____	_____	Spring _____	Fall _____

Thomas Y.L. Hung, MD  
Facial Plastic & Reconstructive Surgery  
Board Certified

Andy T.A. Chung, MD, FACS  
Head & Neck Surgical Oncology  
Board Certified

Lindsey De Leon, Au.D., FAAA  
Audiology  
AAA Fellow