DALLAS ENT GROUP

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

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? ___________________

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History of Medical Treatment:

Check below any medications used- past or present.

Decongestants/Mucolytic/Antihistamines

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

Intranasal Steroids

Medication		Medication	
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		

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

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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 _________

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