



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? _____

History of Medical Treatment:

Check below any medications used- past or present.

Decongestants/Mucolytic/Antihistamines

- Sudafed or any similar over-the-counter medications _____
- Prednisone _____
- Mucinex/ Mucinex D _____
- Claritin/ Claritin D _____
- Allegra/ Allegra D _____

- Clarinex _____
- Xyal _____
- Astelin/Astepro _____
- Patanase _____
- Other _____



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Zyrtec/ Zyrtec D _____

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 _____	_____	_____
Levaquin 750 _____	_____	_____
Avelox _____	_____	_____
Omnicef _____	_____	_____
Zithromax _____	_____	_____
Doxycycline _____	_____	_____
Other _____	_____	_____

Allergy History:

- Have you ever been allergy tested? (Please circle one) Yes / No



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• 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 _____