MY SINUS HISTORY

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Name: _____ Date: _____

Complaint: ❑ Headache ❑ Difficulty breathing ❑ Sinus infections

When did symptoms start? ❑ Childhood ❑ Teen ❑ Adult

HEADACHES/FACIAL PAIN

How many per month? _____ How many hours does headache last? _____

Are they worse in the: ❑ Morning ❑ Afternoon ❑ Evening ❑ Constant pain which gets worse

Severity: ❑ Mild ❑ Moderate ❑ Severe

Pain Quality: ❑ Dull ❑ Sharp ❑ Throbbing

Location: ❑ Above the eyes ❑ Below the eyes ❑ Behind the eyes ❑ Between the eyes

❑ Top of head ❑ Over cheeks ❑ Other _____

Associated symptoms: ❑ Nausea ❑ Tearing ❑ Eye symptoms ❑ Congestion

Symptoms worsen with exposure to: ❑ Pressure changes ❑ Cigarette smoke ❑ Perfumes ❑ Loud noise ❑ Bright lights ❑ Weather changes ❑ Cleaning products

❑ Other _____

DIFFICULTY BREATHING/MOUTH BREATHING

Is congestion worse when lying down? ❑ Yes ❑ No

Which side is affected? ❑L ❑R ❑ Both

Mouth breathing: ❑ Always ❑ Sometimes ❑ Never ❑ At night

Do you have problems with: ❑ Smell ❑ Bad breath ❑ Sore throat ❑Taste ❑ Cough ❑ Aching teeth ❑ Hoarseness ❑ Frequent throat clearing

Do you have to "fuss" with your nose in the morning? ❑ Yes ❑ No

SINUSITIS

Number of antibiotic therapies taken in last year? _____

Last antibiotic therapy? (month/year)_____

Relief from antibiotic therapies? ❑ A lot ❑ Somewhat ❑ Not much

Side effects from antibiotics: ❑ None ❑ Allergies ❑ Stomach problems ❑ Vaginitis

Post nasal drip/runny nose: ❑ Lots ❑ Little ❑ Never Color: _____

Sleep disturbances: ❑ No problems ❑ Snoring ❑ Sleep Apnea

Dizziness: ❑ Yes ❑ No Describe: _____

Do you think your symptoms are: ❑ Progressive ❑ Stable ❑ Affect quality of life

Do you miss work/school? ❑ Yes ❑ No Days missed per year:_____

Are your sinus/nose problems something you cope with everyday? ❑ Yes ❑ No

ALLERGIES

Do you think you have: ❑ Allergies ❑ Asthma ❑ Eczema ❑ Hives ❑ Migraines

Have you been tested for allergies? ❑ Yes ❑ No Have you had allergy shots? _____

Do you use: ❑ Over the counter sprays ❑ Saline irrigations ❑ Cortisone nasal spray ❑ Prescription antihistamines ❑ Over the counter antihistamines ❑ Other _____

Please list your sinus medications:_____

Have you had sinus x-ray: ❑ Yes ❑ No

CT Scans: ❑ Yes ❑ No Results: ❑ Normal ❑ Abnormal

Operations: Septal Surgery: ❑ Yes ❑ No Year _____

Sinus Surgery: ❑ Yes ❑ No Year _____