DALLAS ENT GROUP

Adult and Pediatric Otolaryngology
12720 Hillcrest Rd, Suite 900
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 check one) Yes / No
  - If yes, how long? _____

History of Medical Treatment:

Check below any medications used- past or present.

Decongestants/Mucolytic/Antihistamines

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

Clarinex ___☐___
Xyxal ___☐___
Astelin/Astepro ___☐___
Patanase ___☐___
Other ___☐___

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Zyrtec/ Zyrtec D ☐

Intranasal Steroids

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

Antibiotics

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

Allergy History:

- Have you ever been allergy tested? (Please check 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 ☐