Ear, Nose and Throat Associates of Northern Colorado

NOSE AND SINUS SYMPTOM SHEET

Name: _____ Age:_____ Date:_____

Please answer the following questions carefully.

What brings you in to see the doctor? _____

_____

1. Are you able to breathe through your nose?	Yes / No
2. Is it harder to breathe out of one side than the other?	Right / Left / Same
3. Does the congestion **alternate** sides?	Yes / No
4. Do you have frequent **nose bleeds**?	Yes / No When was your last episode: How frequent:
5. Do you feel you have increased nasal drainage **or** post nasal drip?	Nasal drainage / Postnasal / Both
6. Is the drainage a color **other than clear**?	Yes / No Specify:
7. Do you have facial pain **or** headaches?	Facial pain / Headaches / Both / Neither Specify:
8. Do you get a fever when having sinus headaches?	Yes / No Specify:
9. Do you **or** your doctor suspect that you have allergies or hay fever?	Yes I have allergies or hay fever / I suspect I may have allergies or hay fever / No known allergies Specify:
10. Do you **or** your doctor suspect you have asthma?	Yes I do asthma / I suspect I may have asthma / I do not have asthma Specify:
11. Do you have excessive sneezing **or** eye irritation?	Yes / No Specify:
12. Do you use nose drops **or** nasal spray?	Yes / No Specify:
13. Have you **ever** smoked? How much?	Currently / Former Quit:_____ / How much:_____ / Never
14. Have you ever had any type of nose or sinus surgery?	Yes / No Specify:
15. Have you been treated with **antibiotics**, if so **how many times** with in the last year?	Yes / No What Medication: How many times:
ADDITIONAL CONCERNS:	