LAKESHORE
EAR, NOSE, THROAT CENTER, PC

Sinus Questionnaire & Health History

GENERAL INFORMATION:

Today's Date: _____/_____/_____

Patient's Name: _____ Date of Birth: _____/_____/_____

Patient's Height: _____ Patient's Weight: _____

Preferred Phone Number: (_____)_____ Email:_____

Primary Care Physician:_____

Did a physician refer you to Lakeshore ENT? ☐Yes ☐ No If "Yes," which physician:_____

Where (hospital system) does your physician send you to for testing? _____

How did you hear about us if you were not referred by a physician? ☐ Family ☐ Friend ☐ Internet ☐ Other

Preferred Pharmacy (name and phone number): _____

CHIEF COMPLAINT (reason for visit): _____

SINUS SYMPTOMS (*please check all that apply*):

How frequently do you have these symptoms?	Sinus Infection	Facial Pressure, Pain, Headache	Nasal Congestion, Stuffiness	Runny Nose, Post-nasal Drip	Nasal Bleeding	Altered Smell	Asthma
Never							
This is the 1st episode							
3 times/year or fewer							
4-6 times/year							
Monthly							
Weekly							
Daily							
Constantly							

Do you HAVE any of the following? If your answer is "No," skip to the next section.

1. Recurrent sinus infections..... ☐ Yes ☐ No
   How often? _____
   What antibiotics have you taken for this? _____
   What's the longest course of antibiotics or steroids you had? _____
   When was your last treatment? _____

2. Nasal discharge or post-nasal drip..... ☐ Yes ☐ No
   If yes, ☐ Left ☐ Right ☐ Both
   If yes, ☐ Discolored ☐ Clear
   If clear, does it taste salty? ☐ Yes ☐ No
   Is it worse with bending, lifting or straining? ☐ Yes ☐ No

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3. Nasal bleeding.....☐ Yes ☐ No
   If yes, ☐ Left ☐ Right ☐ Both
   If yes, ☐ Mild ☐ Moderate ☐ Severe
   Is it worse in the winter? ☐ Yes ☐ No
   Is it worse with nose sprays? ☐ Yes ☐ No

4. Nasal congestion or blockage.....☐ Yes ☐ No
   If yes, ☐ Left ☐ Right ☐ Both
   If both, is it alternating? ☐ Yes ☐ No
   Please list things that make the congestion worse (e.g., smoking, allergies, infections, lying down).
   _____

5. Facial, pressure, pain, or headache..... ☐ Yes ☐ No
   When did this first begin? _____
   Which side of your head or face is affected? ☐ Left ☐ Right ☐ Both
   What locations are affected? ☐ Forehead ☐ Cheeks ☐ Behind the eyes ☐ Temples
   ☐ Back of head ☐ Neck ☐ Teeth
   How would you best describe the pressure or pain? ☐ Dull ache ☐ Sharp stabbing
   ☐ Pressure ☐ Throbbing
   What triggers the pressure or pain? ☐ Weather changes ☐ Allergies
   ☐ Menstrual cycle ☐ Foods
   Do you get associated nausea or vomiting? ☐ Yes ☐ No
   Do you get light sensitivity? ☐ Yes ☐ No
   Is there a family history of migraines? ☐ Yes ☐ No
   Have you been diagnosed with migraines? ☐ Yes ☐ No
   Have you been diagnosed with TMJ (jaw issues), or told you clench/grind your teeth? ☐ Yes ☐ No

6. Have you had prior imaging of your head or sinuses…….....☐ Yes ☐ No
   If yes, what did you have? ☐ CT (cat scan) ☐ MRI
   If yes, do you have a copy of the results or a disc? ☐ Yes *(please bring to next visit)* ☐ No

7. Do you suffer from allergy symptoms?.....☐ Yes ☐ No
   If "Yes," which symptoms? ☐ Sneezing fits ☐ Itchy eyes ☐ Itchy nose ☐ Scratchy throat
   ☐ Watery eyes ☐ Runny nose
   How long have you had these symptoms? _____
   When are the symptoms worse? ☐ Spring ☐ Summer ☐ Fall ☐ Winter
   Have you ever been tested for allergies? ☐ Yes ☐ No
   If so, who tested you and what were you allergic to? _____
   How long ago was the testing? _____
   Did you get allergy shots? ☐ Yes ☐ No
   How long did you get the shots? _____
   Do you think the shots helped? ☐ Yes ☐ No
   Did you have to stop the shots prematurely? ☐ Yes ☐ No

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8. Smell or taste changes.....☐ Yes ☐ No
   When did this first begin? _____
   What was affected? ☐ Smell ☐ Taste ☐ Both
   Is the sensation lost? ☐ Yes ☐ No
   Is the sensation altered? ☐ Yes ☐ No If "Yes," in what way? _____
   Is your sense of smell diminished with infections? ☐ Yes ☐ No
   Do antibiotics or steroids make these symptoms better? ☐ Yes ☐ No

Which describes your experience with the following therapies for each problem? 0 – Never used 1 = No relief 2 = Some relief but difficulty tolerating 3 = Some partial or temporary relief 4 = Significant relief ***(enter the best number for each therapy used in the boxes below each symptom)***	**Sinus Infection**	**Facial Pressure, Pain, Headache**	**Nasal Congestion, Stuffiness**	**Nasal Discharge**	**Altered Smell**	**Asthma**
Antibiotics						
Anti-fungal therapy (Sporanox, Vfend, Ampho B)						
Anti-histamines (Benadryl, Claritin, Allegra, Zyrtec)						
Decongestants (Sudafed, Entex, Etc.)						
Topical nasal steroid sprays (Nasacort, Rhinocort, Flonase, Nasonex)						
Steroids by mouth or injection (Medrol or Prednisone)						
Over-the-counter nose sprays (e.g., Afrin)						
Aspirin, Tylenol, Anti-inflammatory						
Prescription pain medications (Codeine, Percocet)						
Antibiotic nasal/sinus irrigations						

MAJOR SURGERIES:

What	**Where (what facility?)**	**When**
1.		
2.		
3.		
4.		

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MEDICATIONS:

Medication list attached: ☐Yes ☐ No If "No," list all current medications below, including dose and frequency:

_____

_____

_____

List medication allergies and reactions: _____

_____

MEDICAL HISTORY (*please check all that apply*):

☐Allergic Rhinitis	☐Cancer (what area of body?		☐Migraines
☐Anesthesia Problems	☐COPD (lung disease)	☐Hepatitis	☐Reflux (GERD)
☐Asthma	☐Diabetes	☐High Blood Pressure	☐Stroke
☐Anxiety	☐Heart Disease	☐Kidney Disease	☐Thyroid Disease
☐Autoimmune Disorder	☐Other (please specify):		
☐Blood Clots			

FAMILY MEDICAL HISTORY (*please check all that apply and note relationship*):

☐ Hearing Loss	☐ Cancer	☐ Heart Disease
☐ Bleeding Disorders	☐ Hearing Loss	☐ High Blood Pressure

SOCIAL HISTORY:

Smoking/tobacco products (cigarettes, cigars, chewing tobacco): ☐Yes ☐No Number of years: Number of packs/day: When did you quit?
What is your occupation? Are you retired? ☐Yes ☐No
Alcohol: ☐Yes ☐No Daily amount: How long? When did you quit?
Do you use recreational/illicit drugs? ☐Yes ☐No If yes, what drugs?
Are you hard of hearing or deaf in one or both ears? ☐Yes ☐No
Do you have special religious, spiritual, or cultural needs that we should to be aware of? ☐Yes ☐No If Yes, please explain:

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REVIEW OF SYSTEMS (*please check all that apply*):

Constitutional: ☐fatigue ☐fever ☐weight loss (_____lbs) ☐weight gain (_____lbs)
Eyes: ☐blurred vision ☐double vision ☐itching ☐burning ☐eye pain
Ears: ☐difficulty hearing ☐ear pain ☐vertigo ☐tinnitus (ringing) ☐ears feel pressured ☐discharge from ears
Nose: ☐frequent nosebleeds ☐nasal congestion ☐nose/sinus problems ☐rhinorrhea (nasal mucus) ☐sinus pressure ☐blockage/obstruction
Mouth/Throat: ☐sore throat ☐bleeding gums ☐snoring ☐dry mouth ☐oral abnormalities ☐mouth ulcer ☐teeth abnormalities ☐difficulty swallowing ☐post nasal drip ☐hoarseness ☐mouth breathing
Neurologic: ☐fainting ☐frequent headaches ☐seizures ☐numbness ☐weakness ☐migraines ☐restless legs
Cardiovascular: ☐chest pain ☐history of heart murmur ☐dyspnea on exertion ☐palpitations ☐edema ☐light-headed on standing
Respiratory: ☐wheezing ☐shortness of breath ☐hemoptysis ☐sputum production ☐sleep apnea ☐cough
Genitourinary: ☐difficulty urinating ☐pain during urination ☐urinary retention
Gastrointestinal: ☐vomiting ☐heartburn ☐painful swallowing ☐no appetite ☐increased appetite
Hematologic/Lymphatic: ☐swollen glands ☐easy bruising ☐excessive bleeding
Psychiatric: ☐depression ☐anxiety ☐restless sleep
Musculoskeletal: ☐muscle aches ☐joint pain/arthralgia
Skin: ☐rash ☐itching ☐dry skin ☐growths/lesions
Endocrine: ☐increased thirst ☐increased drinking ☐increased hunger
Allergy/Immunologic: ☐frequent sneezing ☐runny nose

Patient/Guardian Signature: _____

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