Proliance South Seattle Otolaryngology

Sino/Nasal Worksheet

Name: _____ DOB: _____ Date: _____

Do you have nasal obstruction/blockage/congestion:

□ Yes, which side is worse □ Right □ Left □ Both

□ No

1. Do you have hay fever/allergies?

□ Yes □ No

2. Do you suspect allergies contributing to your congestion?

□ Yes □ No

3. Have you been tested for allergies?

□ Yes, result _____ □ No

4. Have you ever had allergy shots (allergy immunotherapy)

□ Yes, for how long? _____ Date stopped _____

Do you use steroid nasal sprays?

Name of spray:

□ Currently _____

□ In the past _____

□ Never

Do you use other allergy medications?

Name of medications:

□ Currently _____

□ In past _____

□ Never

How many sinus infections have you been treated for in the past year? _____

How many of these infections were treated with antiobiotics?

Name of antibiotic _____

Length of treatment _____

Have you had a recent CT or MRI of your head/sinuses?

□ No

□ Yes Date _____ Location _____

Have you had prior sinus or nasal surgery? □ No □ Yes Date_____ Location _____

Please check all symptoms that apply. Rate 0-10, 10 most severe. Circle your worst symptom.

□ Nasal drainage	_____	□ Sneezing	_____
□ Decreased sense of smell	_____	□ Itchy eyes or nose	_____
□ Headache, location _____	_____	□ Watery eyes or nose	_____
□ Facial □ pain □ pressure	_____	□ Postnasal drainage	_____
□ Nasal bleeding ___ Right ___ Left	_____	□ Coughing	_____