

SINUS HISTORY QUESTIONNAIRE

please complete if you are having any sinus symptoms

NAME: _____

D.O.B: _____

PCP: _____

Date: _____



How many sinus infections do you experience per year? _____ For how many years? _____

How long does each sinus infection typically last? _____ When was the last one? _____

What symptoms do you experience with your sinus infections? *Check ALL that apply*

<input type="checkbox"/> discolored nasal drainage	<input type="checkbox"/> headaches	<input type="checkbox"/> facial pain	<input type="checkbox"/> post nasal drip
<input type="checkbox"/> clear nasal drainage	<input type="checkbox"/> nasal stuffiness	<input type="checkbox"/> decreased sense of smell	

Have you used/tried the following for your sinus infections?

NASAL SPRAYS	Circle	For how long?	Currently using?	Did it help?
Flonase (fluticasone)	YES NO		YES NO	YES NO
Nasacort (triamcinolone)	YES NO		YES NO	YES NO
Nasonex (mometasone)	YES NO		YES NO	YES NO
Astelin (azelastine)	YES NO		YES NO	YES NO
Atrovent (Ipratropium Bromide)	YES NO		YES NO	YES NO
saline sprays	YES NO		YES NO	YES NO
saline irrigations	YES NO		YES NO	YES NO

ANTIBIOTICS	Circle	For how long?	Currently using?	Did it help?
Amoxicillin	YES NO		YES NO	YES NO
Augmentin (amoxicillin-clavulanate)	YES NO		YES NO	YES NO
Z-Pack (azythromycin)	YES NO		YES NO	YES NO
Doxycycline	YES NO		YES NO	YES NO
Bactrim	YES NO		YES NO	YES NO
Gentamicin Rinses/Budesonide	YES NO		YES NO	YES NO
Keflex (cephalexin)	YES NO		YES NO	YES NO

OVER THE COUNTER MEDICATIONS	Circle	For how long?	Currently using?	Did it help?
Sudafed (pseudophedrine)	YES NO		YES NO	YES NO
Sudafed PE (phenylephrine)	YES NO		YES NO	YES NO
Mucinex (guaifenesin)	YES NO		YES NO	YES NO
Claritin (loratadine)	YES NO		YES NO	YES NO
Zyrtec (cetirizine)	YES NO		YES NO	YES NO
Allegra (fexofenadine)	YES NO		YES NO	YES NO
Xyzal (levocetirizine)	YES NO		YES NO	YES NO
Singulair (montelukast)	YES NO		YES NO	YES NO
Other:	YES NO		YES NO	YES NO

Have you seen another physician for sinus issues? YES NO

If so, who (name and phone number): _____

Have you had allergy testing? YES NO Comments: _____

Have you ever had a sinus CT? YES NO Where: _____ When: _____

Have you ever had nasal/sinus surgery? YES NO Comments: _____