NORTH COUNTY EAR, NOSE, & THROAT
HEAD AND NECK SURGERY, INC.
Pediatric and Adult
Diplomats, American Board of Otolaryngology

SINUS QUESTIONAIRE Date _____

Name _____

Date of Birth _____

Please answer the following questions.

1. How long have you had sinus problem? _____

_____

2. About how many weeks out of the past 6 months have you had sinus problems? _____

_____

3. About how many weeks out of the past 6 months have you been on antibiotics? _____

_____

4. What medications have you tried and what was their affect?_____

_____

5. Any idea why you have sinus problems? _____

_____

6. Have the sinus problems been with you constantly, e.g. almost every day of the month, or intermittently, e.g. about 10 days or less per month? _____

_____

7. Please list your chronic, daily in and day out sinus symptoms. _____

_____

8. Please list any other sinus symptoms that occur intermittently. _____

_____

9. Which of your symptoms bother you the most? _____

_____

10. How much of a problem to you are your sinus symptoms? _____

_____

Date _____

Name _____

Date of Birth _____

Yes No Even though you may have already noted these, please tell me which of these you have.

____ ____ Significant amount of time lost from daily routine, work, a school because of sinus problems

____ ____Allergies

____ ____Frequent plane flights

____ ____Frequent exposure to others with colds or other infections

____ ____Fevers

____ ____Fatigue

____ ____Nasal congestion

____ ____Discolored nasal drainage

____ ____Clear nasal drainage

____ ____Postnasal drip

____ ____Clenching jaws or grinding teeth

____ ____Bad breath

____ ____Sore throat

____ ____Hoarseness

____ ____Frequent need to clear her throat

____ ____Very dry eyes or mouth

____ ____Sinus x-rays or sinus CT

____ ____Cough

____ ____Asthma

____ ____Bronchitis, emphysema, or episodes of pneumonia

____ ____Problems with immune system

____ ____Headaches

____ ____Diminished sense of taste

____ ____Diminished sense of smell

____ ____Lots of sneezing

____ ____Eyes and/or throat itch

____ ____Prior allergy evaluation

For office use only

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