Sinus Center Idaho

Idaho's First Sinus Care Clinic

My Sinus History

Name: _____ **DOB:** _____ **Date:** _____

Were you referred to Sinus Center – Idaho? ____ No ____ Yes **Who:** _____

Complaint: ____ Headache ____ Difficulty breathing ____ Sinus Infections

When Did Your Symptoms Start? ____ Childhood ____ Teen ____ Adult

SINUSITIS

Number of antibiotic(s) taken in the last year: _____ **Last date of antibiotic therapy:** _____

Relief from antibiotic(s): ____ A Lot ____ Some ____ Very little, if any

Side effects from antibiotics: ____ None ____ Allergies ____ Stomach Problems ____ Vaginitis

HEADACHES & FACIAL PAIN/PRESSURE

How many headaches per month: ____ **On average, how long does your headache last:** _____hour(s)

Worse in the: ____ Morning ____ Afternoon ____ Evening ____ Constant Pain Which Gets Worse

Severity: ____ Mild ____ Moderate ____ Severe **Pain Quality:** ____ Dull ____ Sharp ____ Throbbing

Location: ____ Top of Head ____ Back of Head ____ Right ____ Left ____ Both Side(s) of Head

Associated Symptoms: ____ Nausea ____ Tearing ____ Eye Symptoms

Headache worsens with exposure to: ____ Pressure Changes ____ Weather Changes ____ Cigarette Smoke

____ Perfumes ____ Cleaning Products Other: _____

Facial Pain/Pressure: ____ No ____ Yes **Location:** ____ Above Eyes ____ Below Eyes ____ Behind Eyes

____ Between Eyes ____ Over Cheeks Other: _____

Facial Pain/Pressure worsens with exposure to: ____ Pressure Changes ____ Weather Changes

Other: _____

OTHER SYMPTOMS

Post Nasal Drainage/Runny Nose: ____ A Lot ____ Some ____ Never

Color of Discharge: ____ Green ____ Yellow ____ White ____ Clear

Sleep Disturbance: ____ None ____ Snoring ____ Apnea **Energy Level:** ____ Normal ____ Low

Dizziness: ____ No ____ Yes Describe: _____

Do You Think Your Symptoms Are: ____ Progressive ____ Stable ____ Affecting the Quality of My Life

Do You Miss Work/School? ____ No ____ Yes **On Average, How Many Days Missed per Year?** _____

Are Your Sinus/Nose Problems You Cope with Every Day? ____ Yes ____ No

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DIFFICULTY BREATHING & MOUTH

Is Congestion Worse When Lying Down? ☐ No ☐ Yes

Which Side is Affected? ☐ L ☐ R ☐ Both ☐ Alters from Side to Side

Mouth Breathing: ☐ Always ☐ Sometimes ☐ At Night ☐ Never

Do You Have Problems With: ☐ Smell ☐ Taste ☐ Bad Breath ☐ Sore Throat ☐ Cough

☐ Aching Teeth ☐ Hoarseness ☐ Frequent Throat Cleaning

Do you have to "fuss" with your nose in the morning? ☐ Yes ☐ No

ALLERGIES

Do You Think You Have: ☐ Allergies ☐ Asthma ☐ Eczema ☐ Hives ☐ Migraines

Have You Had Allergy Testing: ☐ Yes ☐ No **Allergy Shots:** ☐ Yes ☐ No

Do You Use: ☐ Over the Counter Sprays ☐ Cortisone Spray ☐ Saline Irrigations

☐ Over the Counter Antihistamines ☐ Prescription Antihistamines

PREVIOUS TREATMENTS

Please list all medical therapy you have tried for your sinuses: _____

_____

Have You Had a Sinus CT: ☐ Yes ☐ No **Results:** ☐ Normal ☐ Abnormal

Operations: **Septal Surgery:** ☐ Yes ☐ No **Year:** _____ **Surgeon:** _____

Amount of relief from surgery? ☐ A Lot ☐ Some ☐ Very Little

Sinus Surgery: ☐ Yes ☐ No **Year:** _____ **Surgeon:** _____

Amount of relief from surgery? ☐ A Lot ☐ Some ☐ Very Little

Family Sinus History: _____

Significant Personal History: _____

How frustrated are you with your sinus condition(s)? _____

_____

Reset Form