

EAR, NOSE AND THROAT ASSOCIATES OF CHESTER COUNTY

NASAL SINUS QUESTIONNAIRE

Name _____ Date _____
Last First MI

1. What symptom(s) bother you most? _____

2. Have you had a previous CT scan(s) of the sinuses? ____ Yes ____ No _____ Date(s)

3. Date and type of previous nasal or sinus surgery: _____

4. What do you hope for as a result of nasal/sinus treatment? _____

5. On a scale of 0 (none) to 10 (terrible, incapacitating), please rank your symptoms:

- * nasal congestion 0 1 2 3 4 5 6 7 8 9 10
- * Nasal drainage 0 1 2 3 4 5 6 7 8 9 10 Color _____
- * post-nasal drip 0 1 2 3 4 5 6 7 8 9 10
- * bad breath 0 1 2 3 4 5 6 7 8 9 10
- * visual disturbances 0 1 2 3 4 5 6 7 8 9 10
- * ear congestion 0 1 2 3 4 5 6 7 8 9 10
- * cough 0 1 2 3 4 5 6 7 8 9 10
- * smell no smell 0 1 2 3 4 5 6 7 8 9 10 normal smell
- * facial pain 0 1 2 3 4 5 6 7 8 9 10

Where is the pain? _____

How often do you get the pain? _____

Describe the pain: _____

What makes it better? _____

* migraine headache 0 1 2 3 4 5 6 7 8 9 10

* tension headache 0 1 2 3 4 5 6 7 8 9 10

* other type of headache 0 1 2 3 4 5 6 7 8 9 10

What is the headache like? _____

What makes it better? _____

Do you have nausea? Yes No

Vomiting? Yes No

Have you seen a Neurologist? Yes No

6. Overall, on a scale from zero to ten, with zero being totally without symptoms and ten being the worst you've ever felt, please rate how you feel now:

0 1 2 3 4 5 6 7 8 9 10

7. Have you been tested for allergies? Yes No

If yes, date: _____ Name of Allergist: _____

What are you allergic to? _____

8. What kind of treatment do you take for your allergies? _____

9. If there is anything else you'd like to tell us, please do so. _____
