Sinus Center™ Idaho

Idaho's first sinus care clinic

my sinus history

Name_____Date_____

Were you referred to Sinus Center-Idaho by a physician? ☐ Yes ☐ No Who?_____

Complaint: ☐Headache ☐Difficulty Breathing ☐Sinus Infections

When did symptoms start? ☐ Childhood ☐Teen ☐Adult

SINUSITIS

Number of antibiotic therapies taken in last year? _____ Last antibiotic therapy? (month/year)_____

Relief from antibiotic therapies? ☐A Lot ☐Somewhat ☐Not much

Side effects from antibiotics: ☐None ☐Allergies ☐Stomach problems ☐Vaginitis

HEADACHES/FACIAL PAIN

How many per month? _____ How many hours does headach last? _____

Are they worse in the ☐Morning ☐Afternoon ☐Evening ☐Constant pain which gets worse

Severity: ☐Mild ☐Moderate ☐Severe Pain Quality: ☐Dull ☐Sharp ☐Throbbing

Location: ☐Above the eyes ☐Below the eyes ☐Behind the eyes ☐Between the eyes ☐Top of head ☐Over Cheeks ☐Other_____

Associated Symptoms: ☐Nausea ☐Tearing ☐Eye symptoms

Symptoms worsen with exposure to: ☐Pressure Changes ☐Cigarette smoke ☐Perfumes ☐ Weather Changes ☐ Cleaning products ☐ Other

OTHER SYMPTOMS

Post nasal discharge/runny nose: ☐Lots ☐Not much ☐Never Color: ☐ Green ☐ Yellow ☐ White ☐ Clear

Sleep Disturbnces: ☐ No problems ☐ Snoring ☐ Apnea Energy Level: ☐ Normal ☐ Low

Dizziness: ☐ yes ☐ no Describe: _____

Do you think your symptoms are: ☐ Progressive ☐ Stable ☐Affecting quality of life

Do you miss work/school? ☐ yes ☐ no Days missed per year:

Are your sinus/nose problems something you cope with everyday? ☐ yes ☐ no

DIFFICULTY BREATHING/MOUTH BREATHING

Is congestion worse when lying down? ☐ Yes ☐ No Which side is affected? ☐ L ☐R ☐ Alt

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

Do you have problems with: ☐ Smell ☐ Bad Breath ☐ Sore throat ☐ Taste ☐ Cough ☐ Aching teeth ☐ Hoarsenesss ☐ Frequent throat clearing

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 been tested for allergies? ☐ Yes ☐ No Have you had allergy shots? ☐ Yes ☐ No

Do you use: ☐ Over the counter sprays ☐ Saline irrigations ☐ Cortisone spray ☐ Prescription antihistamines ☐Over the counter antihistamines

TREATMENTS

Please list your medications_____

Have you had sinus x-rays? ☐ Yes ☐ No Results: ☐ Normal ☐ Abnormal

CT Scans: ☐ Yes ☐ No Results: ☐ Normal ☐ Abnormal

Septal surgery: ☐Yes ☐ No Year?_____Amount of relief from surgery: ☐ Lot ☐ Little ☐ None

Sinus Surgery: ☐Yes ☐No Year? _____Amount of relief from surgery: ☐ Lot ☐ Little ☐ None

Family history: _____

Significant personal history: _____

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