UT Physicians

UTHealth | McGovern Medical School
The University of Texas Health Science Center at Houston

Established Patient Questionnaire

Texas Sinus Institute

Name	MRN	DOB	Date

Telephone
H W M

Pharmacy
Name Telephone

How did you hear about us?
□ Sent by another physician (If so, please give name below.)
□ Sent by a friend
□ Internet search
□ UT and/or TSI reputation
□ Other *(Specify)*

Physician #1 (☐ sent by this physician)
Name Fax Telephone

Address City, State Zip

Physician #2 (☐ sent by this physician)
Name Fax Telephone

Address City, State Zip

Important Note on Medical Records and Previous Imaging

Please be sure to bring your previous medical records. In particular, previous CT scans and MRI scans of the nose and sinuses are very important. Please try to obtain the actual films (not just the radiology reports); images on CD-ROM are preferable.

START HERE:

What symptom gives you the most trouble?

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The following rating scale will be used to complete the questions:

Scale		Severity Definition
0	**None**	*Absent-NO symptom evident*
1	**Mild**	*Symptom clearly PRESENT but minimal awareness; easily tolerated*
2	**Moderate**	*Definite awareness of symptom that is bothersome, but tolerable*
3	**Severe**	*Symptom is hard to tolerate; interferes with activities of daily living and/or sleeping*

Using the rating scale above, please rate the following symptoms according to how you feel right now.

	None	Mild	Moderate	Severe
Facial or sinus pressure (pressure or fullness in the area behind the eyes, cheeks, forehead, or sinuses)	☐	☐	☐	☐
Facial or sinus pain (pain in the area around the eyes, cheeks, forehead)	☐	☐	☐	☐
Headache (dull to intense, throbbing pain in head)	☐	☐	☐	☐
Nasal congestion (stopped up or stuffy nose)	☐	☐	☐	☐
Nasal obstruction (inability to move air through the nose)	☐	☐	☐	☐
Post-nasal drip (sinus drainage in the back of the throat)	☐	☐	☐	☐
Clear nasal discharge (nasal mucus that is clear)	☐	☐	☐	☐
Discolored nasal discharge (nasal mucus that is green, yellow, and/or brown)	☐	☐	☐	☐
Itchy nose/eyes/throat (sensation of itchiness in the nose, eyes and/or throat)	☐	☐	☐	☐
Nose bleeds (bleeding, not bloody mucus, from the nose)	☐	☐	☐	☐
Tiredness (feeling worn out or drained due to chronic sinusitis)	☐	☐	☐	☐
Wheezing (whistling sound from breathing, associated with chest tightness)	☐	☐	☐	☐
Cough	☐	☐	☐	☐
Sense of smell (reduced sense of smell or detection of bad odor)	☐	☐	☐	☐

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SCAN THIS PAGE.

Below you will find a list of symptoms and social/emotional consequences of your rhinosinusitis. We would like to know more about these problems and would appreciate your answering the following questions to the best of your ability. There are no right or wrong answers, and only you can provide us with this information. Please rate your problems as they have been over the past two weeks. Thank you for your participation. Do not hesitate to ask for assistance if necessary.

Important: *Please mark the most important items affecting your health (maximum of 5 items).*

Considering how severe the problem is when you experience it and how frequently it happens, please rate each item below on how "bad" it is by circling the number that corresponds with how you feel using this scale:	No Problem	Very Mild Problem	Mild or Slight Problem	Moderate Problem	Severe Problem	Problem as Bad as It Can Be		Most Important Items
1. Need to blow nose	0	1	2	3	4	5		O
2. Sneezing	0	1	2	3	4	5		O
3. Runny nose	0	1	2	3	4	5		O
4. Cough	0	1	2	3	4	5		O
5. Post-nasal discharge (dripping at the back of your nose)	0	1	2	3	4	5		O
6. Thick nasal discharge	0	1	2	3	4	5		O
7. Ear fullness	0	1	2	3	4	5		O
8. Dizziness	0	1	2	3	4	5		O
9. Ear pain	0	1	2	3	4	5		O
10. Facial pain/pressure	0	1	2	3	4	5		O
11. Difficulty falling asleep	0	1	2	3	4	5		O
12. Wake up at night	0	1	2	3	4	5		O
13. Lack of a good night's sleep	0	1	2	3	4	5		O
14. Wake up tired	0	1	2	3	4	5		O
15. Fatigue	0	1	2	3	4	5		O
16. Reduced productivity	0	1	2	3	4	5		O
17. Reduced concentration	0	1	2	3	4	5		O
18. Frustrated/restless/irritable	0	1	2	3	4	5		O
19. Sad	0	1	2	3	4	5		O
20. Embarrassed	0	1	2	3	4	5		O
21. Sense of taste/smell	0	1	2	3	4	5		O
22. Blockage/congestion of nose	0	1	2	3	4	5		O

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Other Treatments

Have you seen another physician since your last visit? If Yes, please provide details.

O Yes
O No

Medications

Please list your current medications.

Please list any other medications that you have taken since your last visit, but are not longer using.

Are you allergic to any medications?

O Yes *Details*
O No
(If yes, please give details.)

Comments