

Name	MRN	DOB	Date
Telephone H	W	M	
Pharmacy Name	Telephone		
How did you hear about us? <input type="checkbox"/> Sent by another physician (If so, please give name below.) <input type="checkbox"/> Sent by a friend <input type="checkbox"/> Internet search <input type="checkbox"/> UT and/or TSI reputation <input type="checkbox"/> Other (<i>Specify</i>)			
Physician #1 (<input type="checkbox"/> sent by this physician)			
Name	Fax	Telephone	
Address	City, State	Zip	
Physician #2 (<input type="checkbox"/> 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?

Next page →

Nasal Symptom Inventory

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)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Facial or sinus pain (pain in the area around the eyes, cheeks, forehead)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Headache (dull to intense, throbbing pain in head)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nasal congestion (stopped up or stuffy nose)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nasal obstruction (inability to move air through the nose)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Post-nasal drip (sinus drainage in the back of the throat)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Clear nasal discharge (nasal mucus that is clear)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Discolored nasal discharge (nasal mucus that is green, yellow, and/or brown)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Itchy nose/eyes/throat (sensation of itchiness in the nose, eyes and/or throat)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nose bleeds (bleeding, not bloody mucus, from the nose)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tiredness (feeling worn out or drained due to chronic sinusitis)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wheezing (whistling sound from breathing, associated with chest tightness)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sense of smell (reduced sense of smell or detection of bad odor)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Next 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		○
2. Sneezing	0	1	2	3	4	5		○
3. Runny nose	0	1	2	3	4	5		○
4. Cough	0	1	2	3	4	5		○
5. Post-nasal discharge (dripping at the back of your nose)	0	1	2	3	4	5		○
6. Thick nasal discharge	0	1	2	3	4	5		○
7. Ear fullness	0	1	2	3	4	5		○
8. Dizziness	0	1	2	3	4	5		○
9. Ear pain	0	1	2	3	4	5		○
10. Facial pain/pressure	0	1	2	3	4	5		○
11. Difficulty falling asleep	0	1	2	3	4	5		○
12. Wake up at night	0	1	2	3	4	5		○
13. Lack of a good night's sleep	0	1	2	3	4	5		○
14. Wake up tired	0	1	2	3	4	5		○
15. Fatigue	0	1	2	3	4	5		○
16. Reduced productivity	0	1	2	3	4	5		○
17. Reduced concentration	0	1	2	3	4	5		○
18. Frustrated/restless/irritable	0	1	2	3	4	5		○
19. Sad	0	1	2	3	4	5		○
20. Embarrassed	0	1	2	3	4	5		○
21. Sense of taste/smell	0	1	2	3	4	5		○
22. Blockage/congestion of nose	0	1	2	3	4	5		○

Next page →

General

How frequently do you have sinus and nasal symptoms?

- This is the first episode.
- 3 times/year
- 4-6 times per year
- Monthly
- Weekly
- Daily
- Constantly

Do your symptoms improve between episodes?

- Yes, they completely improve
- No, they never improve
- Sometimes, they improve
- They improve partially

How often do your baseline symptoms get worse?

- Never (The symptoms are always the same.)
- 1-3 times/year
- 4-6 times per year
- More than 6 times per year

Which best describes your sense of smell?

- No problem with sense of smell
- Diminished sense of smell
- Loss of smell
- Detect bad odor

Have you ever had a sinus CT or MRI scan?

- Yes
- No

If yes, please provide details (including dates) below.

Have you ever had a sinus or nasal surgery?

- Yes
- No

If yes, please provide details (including dates) below.

Details

Allergy Page

Do you have any of these allergy symptoms?

- Sneezing fits
- Itchy ears
- Itchy eyes
- Itchy nose
- Runny nose
- Itchy throat
- Runny/watery eyes
- Scratchy roof of your mouth

When are your allergy symptoms most apparent?

- Spring
- Summer
- Fall
- Winter
- Continuously throughout the year

Have you ever been tested for allergy?

- Never
- I have had skin testing for allergy.
- I have had blood testing for allergy.

Have you received allergy shots?

- Never
- Yes, and they helped a great deal.
- Yes, and they helped somewhat.
- Yes, and they did nothing.

Asthma

Do you have asthma?

- Yes
- No

If yes, what do you take for your asthma?

- Asthma inhalers
- Nebulizer treatments
- Oral steroids
- Theophylline
- Other

Trauma

Have you ever broken your nose?

- Yes
- No

Have you ever sustained other facial and/or head injuries?

- Yes
- No

Next page →

Previous Treatments

Which antibiotics have you received over the past year?

- Amox and/or PCN
- Amox/clav (Augmentin)
- Azithromycin (Zithromax, Z-pak)
- Cefadroxil (Duricef)
- Cefdinir (Omnicef)
- Cefpodoxime (Vantin)
- Cefprozil (Cefzil)
- Cefuroxime (Ceftin)
- Cephalexin (Keflex)
- Ciprofloxacin (Cipro)
- Clarithromycin (Biaxin)
- Erythromycin
- Levofloxacin (Levaquin)
- Loracarbef (Lorabid)
- Moxifloxacin (Avelox)
- SMP/TMX (Bactrim, Sulfa)
- IV antibiotics
- Others
- Unknown
- None

Which antihistamines have you received over the past year?

- Cetirizine (Zyrtec)
- Cetirizine/decongestant (Zyrtec-D)
- Desloratadine (Clarinet)
- Desloratadine/decongestant (Clarinet-D)
- Diphenhydramine (Benadryl)
- Fexofenadine (Allegra)
- Fexofenadine/decongestant (Allegra-D)
- Levocetirizine (Zyzal)
- Loratadine (Claritin)
- Loratadine/decongestant (Claritin-D)
- Others
- Unknown
- None

Which nasal sprays have you used over the past year?

- Beclomethasone (Qnasal, Beconase)
- Budesonide (Rhinocort)
- Ciclesonide (Omnaris)
- Flunisolide (Nasarel)
- Fluticasone furoate (Veramyst)
- Fluticasone propionate (Flonase)
- Mometasone (Nasonex)
- Triamcinolone (Nasacort)
- Oxymetazoline (Afrin)
- Azelastine (Astelin)
- Fluticasone/azelastine (Dymista)
- Olopatadine (Patanase)
- Ipratropium bromide (Atrovent)
- Others
- Unknown
- None

What other treatments have you used over the past year?

- Montelukast (Singulair)
- Zileuton (Zyflo)
- Antifungal treatments
- Guaifenesin OTC (Mucinex)
- Nasal saline sprays
- Nasal saline irrigations
- Oral decongestants
- Systemic steroids
- Topical antibiotic irrigations/treatments
- Others
- Unknown
- None

Next page →

Review of Systems

The following is a list of common symptoms and health problems. Please review the list and indicate with a check mark the symptoms and health problems that you are experiencing.

	Yes	No	Treated by another physician
General			
Nausea	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Weight gain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Weight loss	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Fevers/chills	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Ears, Nose & Throat			
Hoarseness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Hearing loss	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Draining ear	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Vertigo	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Loud snoring	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Daytime sleepiness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Mouth sores	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Tooth problems	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Painful/difficult swallowing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Ringing in the ears	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Eyes			
Double vision	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Blurry vision	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Cardiac			
Chest pain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Short of breath	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Respiratory			
Wheezing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Cough	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

	Yes	No	Treated by another physician
Gastro-intestinal			
Heartburn	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Belly pain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Diarrhea	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Constipation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Vomiting	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Skin			
Rashes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Ulcers	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Musculo-skeletal			
Muscle pain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Muscle weakness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Endocrine			
Cold intolerance	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Heat intolerance	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Excessive thirst	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Hematologic			
Anemia	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Bleeding	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Bruising	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Neurological			
Seizures	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Psychiatric			
Depression	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Anxiety	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Next page →

Past History

Do you have any of the following medical problems?

- Arthritis
- Asthma
- Bleeding disorder
- Cataracts
- Chronic fatigue syndrome
- Depression
- Diabetes
- Fibromyalgia
- Gastritis
- Glaucoma
- Hepatitis
- High blood pressure
- Heart disease
- Immunodeficiency
- Kidney disease
- Meningitis
- Migraine headache
- Mitral valve prolapse
- Peptic ulcer disease
- Seizures
- Thyroid disease
- Tuberculosis (TB)

Please list your previous surgical procedures.

Please list your previous hospitalizations.

Do you have any other medical problems not listed above?

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

Please list your current medications.

Are you allergic to any medications?

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

Family History

Do any of your family members have any of the following conditions?

(Please specify the family member.)

- Allergy
- Asthma
- Bleeding disorder
- Cancer
- Cystic fibrosis
- Heart disease
- Immunodeficiency

Social History

What is your occupation?

Have you had any recent change in your home or work environment? Details

- Yes
- No

Do you smoke? Details

- Yes
- No

Do you drink alcoholic beverages? Details

- Yes
- No

Have you ever used cocaine or other illicit substances? Details

- Yes
- No.