HARVARD MEDICAL SCHOOL MASSACHUSETTS EYE AND EAR INFIRMARY

SINUS CENTER SINUSITIS INFORMATION FORM

IF YOU ARE BEING SEEN FOR SINUSITIS PLEASE ANSWER THE FOLLOWING QUESTIONS

Name: _____ Date: _____

DO YOU HAVE ANY OF THE FOLLOWING SYMPTOMS?

☐Nasal Drainage	Duration(Months)_____	#Times/year _____
☐Nasal Congestion/Blockage	Duration(Months)_____	#Times/year _____
☐Facial Pain/Pressure or Headache	Duration(Months)_____	#Times/year _____
☐Post Nasal Drip	Duration(Months)_____	#Times/year _____
☐Decreased Smell/Taste	Duration(Months)_____	#Times/year _____

1) HAVE YOU HAD ANY SINUS OR NASAL SURGERY(if yes, when)? _____
2) IN THE PAST YEAR HOW MANY TIMES HAVE YOU BEEN ON ANTIBIOTICS? _____
3) HAVE YOU EVER USED ANY NASAL STEROID SPRAYS(ie. Flonase, Rhinocort, etc..)? _____
4) HAVE YOU BEEN TREATED WITH ORAL STEROIDS IN THE PAST YEAR? _____
5) HAVE YOU EVER BEEN ON ANTIHISTAMINES(ie. Claritin, Allegra, etc..)? _____
6) HAVE YOU EVER BEEN TESTED FOR ALLERGIES? _____
7) IF YES WHAT ARE YOUR ALLERGIES(ie. dust, mold, pollen, etc..)? _____
8) DO YOU HAVE A HISTORY OF ASTHMA? _____
9) DO YOU OR HAVE YOU EVER SMOKED(If yes, how long, packs/day)? _____

Please grade each the following symptoms on a 0-5 scale (0-Not a problem for me; 5-Worst problem possible)

Please "X" your 5 worst symptoms in this column

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. Nasal Obstruction	0	1	2	3	4	5	
5. Loss of Smell or Taste	0	1	2	3	4	5	
6. Cough	0	1	2	3	4	5	
7. Post-Nasal Discharge	0	1	2	3	4	5	
8. Thick Nasal Discharge	0	1	2	3	4	5	
9. Ear Fullness	0	1	2	3	4	5	
10. Dizziness	0	1	2	3	4	5	
11. Ear Pain	0	1	2	3	4	5	
12. Facial Pain/Pressure	0	1	2	3	4	5	
13. Difficulty Falling Asleep	0	1	2	3	4	5	
14. Wake Up At Night	0	1	2	3	4	5	
15. Lack of Good Night's Sleep	0	1	2	3	4	5	
16. Wake Up Tired	0	1	2	3	4	5	
17. Fatigue	0	1	2	3	4	5	
18. Reduced Productivity	0	1	2	3	4	5	
19. Reduced Concentration	0	1	2	3	4	5	
20. Frustrated/Restless/Irritable	0	1	2	3	4	5	
21. Sad	0	1	2	3	4	5	
22. Embarrassed	0	1	2	3	4	5	