Head and Neck Associates of Orange County, Inc.

An Incorporated Medical Group

Head & Neck Surgery Pediatric & Adult Otolaryngology Facial Reconstructive Surgery

Name:_____ **Date**_____

New Patient Sinusitis History Form

1. What is the reason for your visit? _____
2. How long have you had this problem? _____ **WEEKS / MONTHS / YEARS**
3. How often does this problem occur? **CONSTANT / COMES AND GOES**
4. On the scale below, circle how troublesome the problem is (1=not bad; 10=very severe).
   1 2 3 4 5 6 7 8 9 10
5. Do you feel congested? **YES / NO**
6. Do you have trouble breathing through your nose? **YES / NO**
   a. Is one side worse? **RIGHT / LEFT / BOTH THE SAME**
7. On the scale below, how is your sense of smell (1=no smell; 10=very good)?
   1 2 3 4 5 6 7 8 9 10
8. Do you have any green/yellow nasal drainage? **YES / NO**
9. Do you have any headache or facial pain/pressure? **YES / NO**
   a. Where is it located? _____
10. Do you have nasal allergies/hay fever? **YES / NO**
    a. Have you ever been allergy tested? **YES / NO**
    b. What allergies were found on the allergy test? **YES / NO**
    c. Have you ever had allergy shots? **YES / NO**
11. Have you ever had nasal or sinus surgery? **YES / NO**
    a. If **YES**, what year? _____
12. Have you ever had a CT Scan? **YES / NO**
    a. If **YES**, please list the location and date: **Location**:_____**Date**:_____
13. Have you ever had a sinus or nasal tumor? **YES / NO**
    a. If **YES**, what previous treatments have you had? _____
14. Place a check next to any medications you have tried for your sinus problems:
    - ☐ Oral Steroids (Prednisone/Medrol)
    - ☐ Antibiotics
    - ☐ Prescription nasal sprays
    - ☐ Vicks
    - ☐ Saline irrigations (NeilMed, NetiPot)
    - ☐ Afrin
    - ☐ Nasacort or Flonase
15. Place a check next to any symptoms you have:
    - ☐ Light/ Sound sensitivity
    - ☐ Cough
    - ☐ Throat clearing
    - ☐ Tickle/ Lump in throat
    - ☐ Post–nasal drip