HILL COUNTRY
Ear, Nose & Throat

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Sinus/Allergy/Congestion/Sleep Apnea/Ear Complaints Questionnaire

Patient Name: _____
DOB: _____
Height: _____
Weight: _____

Do you suffer from Allergy Symptoms? (*Circle all the apply*)

Sneezing/Coughing Sore Throat Post Nasal Drip (Drainage to Throat)

Itchy/Watery Eye Burning/Dryness of the Eye

Do you experience Headaches?	**YES**	**NO**
Do you experience: Sinus Pressure/Pain? (*Pressure or Pain to the Face*)	**YES**	**NO**
Thick Nasal Discharge?	**YES**	**NO**
Runny Nose?	**YES**	**NO**
Nasal Congestion? (*Stuffy Nose*)	**YES**	**NO**
Are you a Mouth Breather?	**YES**	**NO**
Do you snore?	**YES**	**NO**
Do you feel like you sleep well at night?	**YES**	**NO**
Are you tired when you wake up?	**YES**	**NO**
Diagnosed with Sleep Apnea?	**YES**	**NO**
Do you have trouble with smell?	**YES**	**NO**
Do you have trouble with taste?	**YES**	**NO**
Do you have trouble with bad breath?	**YES**	**NO**

Do you have ear complaints? (*Circle all the apply*)

Ear Pain Ear Popping Ear Fullness Muffled Sound Ear Ringing

Ear Pressure Ear Drainage Decreased Hearing Dizziness

Have you had sinus surgery in the past? YES NO
If yes, what year? _____
How many years have you suffered with sinus problems? _____
How many times a year do you suffer with sinus symptoms? _____
What medications are you <u>currently on or taken in the past</u>? (*Circle all the apply*)

Allegra Zyrtec Claritin Nasonex Flonase Dymista

Nasacort Steroid Injections Oral Steroids Singulair Sinus Rinses Afrin

Which antibiotics (if any) have you been on for sinus infections?

Augmentin Levaquin Amoxicillin Azithromycin (Z-pak) Cefdinir

Doxycycline Bactrim Other Antibiotic _____

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