



LAKESHORE EAR NOSE THROAT SINUS QUESTIONNAIRE REPRINTED WITH PERMISSION FROM

DATE OF APPOINTMENT: _____

INITIAL OFFICE VISIT SINUS/NASAL QUESTIONNAIRE

TODAY'S DATE: _____

Name: _____ Birth Date: _____ / _____ / _____ Age: _____
Last First MI Month Day Year

Please answer all the questions to the best of your ability and return this completed form to us prior to your office visit either by mail or by faxing it to 586-254-7201. If you have additional information to add, please write in the margins.

If there were only one symptom we could help you with, which would you have us relieve? _____
 How long have you had this symptom? _____

HISTORY OF PRESENT ILLNESS

Below is a list of symptoms of chronic nasal and sinus problems. **CIRCLE ONE ANSWER FOR EACH SYMPTOM.** Please mark an answer for current symptoms and past symptoms that are directly related to why you are seeing us.

- 0 = **Do not have** this symptom
- 1 = Symptom **does not limit** my physical, social or work activity
- 2 = Symptom **mildly limits** my physical, social or work activity
- 3 = Symptom **moderately limits** my physical, social or work activity
- 4 = Symptom **severely limits** my physical, social or work activity

SYMPTOM						SYMPTOM								
Nasal/sinus infections	0	1	2	3	4	Nasal bleeding	0	1	2	3	4			
Nasal stuffiness/congestion	0	1	2	3	4	Altered smell/taste	0	1	2	3	4			
Facial swelling	0	1	2	3	4	Fever	0	1	2	3	4			
Headache	0	1	2	3	4	Fatigue	0	1	2	3	4			
Facial pain or pressure	0	1	2	3	4	Ear fullness /Ear clicking	0	1	2	3	4			
Dental pain	0	1	2	3	4	Bad breath	0	1	2	3	4			
Discolored nasal drainage	0	1	2	3	4	Worsening asthma	0	1	2	3	4			
Post-nasal drainage	0	1	2	3	4	Cough	0	1	2	3	4			
Other (specify)	0	1	2	3	4	Other (specify)	0	1	2	3	4			
How long have you had this symptom?	Sinus Infection		Facial Pressure, Pain, Headache		Nasal Blockage, Stuffiness		Runny Nose/ Post-nasal drip		Nasal Bleeding		Altered Smell		Asthma	
Do not have/have not had this symptom														
Less than 3 months														
More than 3 months but less than 1 year														
1 to 2 years														
More than 2 years														
Since childhood														
Other														

How has the symptom changed over time?	Sinus Infection	Facial Pressure, Pain, Headache	Nasal Congestion, Stuffiness	Runny Nose/ Post-nasal drip	Nasal Bleeding	Altered Smell	Asthma
Better than in the past							
No change							
Worse than in the past							
How frequently do you have these symptoms?	Sinus Infection	Facial Pressure, Pain, Headache	Nasal Congestion, Stuffiness	Runny Nose/ Post-nasal drip	Nasal Bleeding	Altered Smell	Asthma
never							
this is the first episode							
3 times/ year or fewer							
4-6 times /year							
monthly							
weekly							
daily							
constantly							
Which best describes your experience with the following therapies for each problem? 0 = Never used 1 = No relief 2 = Some relief but difficulty tolerating 3 = Some partial or temporary relief 4 = Significant relief Enter the number in the boxes below	Sinus Infection	Facial Pressure, Pain, Headache	Nasal Congestion, Stuffiness	Nasal Discharge		Altered Smell	Asthma
Antibiotics							
Anti-fungal therapy (Sporanox, Vfend, Ampho B)							
Anti-histamines (Benadryl, Claritin, Allegra, Zyrtec)							
Decongestants (Sudafed, Entex, etc.)							
Topical nasal steroid sprays (Nasacort, Rhinocort, Flonase, Nasonex)							
Steroids - by mouth or injection (Medrol or Prednisone)							
Over-the-counter nose sprays (e.g. Afrin)							
Aspirin/Tylenol/Anti-inflammatory							
Prescription pain medications (Codeine, Percocet)							
Antibiotic nasal/sinus irrigations							

DO YOU HAVE ANY OF THE FOLLOWING?

RECURRENT or CHRONIC NASAL/SINUS INFECTIONS

no yes yes, this is my main complaint
(if "no" go to the next section Nasal Discharge/Drainage)

To the best of your recollection, please list all the antibiotics you have taken for nasal/sinus infections: _____

Which describes the **longest** period of time you were on continuous, uninterrupted antibiotic therapy?

- less than 10 days
- 10 days to less than 2 weeks
- 2 weeks to less than 1 month
- 1 to 2 months
- more than 2 months
- can't recall

NASAL DISCHARGE/DRAINAGE, POST-NASAL DRIP or RUNNY NOSE

no yes yes, this is my main complaint
(if "no" go to the next section Nasal Bleeding)

Please describe when you first developed these symptoms: _____

Does the drainage appear mostly after eating? no yes not sure

Have you had your typical drainage today? no yes

In which direction does the drainage usually pass?

- forward, out of my nose
- backwards into my throat
- both forwards and backwards

Which side of your nose is most affected?

- right
- left
- both

Is the drainage usually discolored or clear?

- discolored
- clear
- sometimes discolored, sometimes clear

Please check all which best describe the typical appearance of your drainage:

- clear yellow green brown
- opaque white blood-tinged black orange

Is the drainage thin and water-like, thin thick both

or thicker like mucus?

If **thin**, does it have a salty taste? no yes not sure

If **thin**, does it appear after bending, lifting, or straining? no yes not sure

NASAL BLEEDING

no yes yes, this is my main complaint
(if "no" go to the next section Nasal Congestion or Blockage)

Please describe when you first developed these symptoms: _____

Please describe the typical amount of blood that is present.

- occasional streaking on tissues
- daily streaking on tissues
- occasional blood clots
- intermittent bouts of heavy bleeding

Have you had nasal bleeding today? no yes

Which side of your nose is most affected? right left both

Do you cough up blood? no yes

Do you have bleeding most often in winter? no yes

Does your nose bleed after nose blowing? no yes

Does bleeding occur with nasal spray use? no yes

How has your nasal bleeding been treated? _____

NASAL CONGESTION or BLOCKAGE (STUFFINESS)

no yes yes, this is my main complaint
(if "no" go to the next section Smell or Taste Changes)

Do you have this blockage/congestion now? no yes

Which side of your nose is **most often** affected? right left both/alternating

Is the congestion/blockage worsened by:

- lying down? no yes not sure
- alcohol consumption? no yes not sure
- tobacco smoke? no yes not sure
- pollution? no yes not sure
- perfumes? no yes not sure
- other environmental irritants (please specify) no yes not sure

SMELL or TASTE CHANGES

no yes yes, this is my main complaint
(if "no" go to the next section Facial Pain/Pressure or Headache)

Which best describes the change in your taste/smell:

- diminished sense of taste loss of taste detect bad taste
- diminished sense of smell loss of smell detect bad odor
- burning tongue sensation

If you have loss of smell,
does your sense of smell ever improve? no yes
Do you detect an odor that other people cannot? no yes
Please describe when you first developed these symptoms:

Do you have decreased or absent sense of smell today? no yes
Do(es) your **smell/taste** symptom(s):
worsen with sinus/nasal infection? no yes not sure
improve with medications/treatment? no yes not sure

FACIAL PAIN/PRESSURE or HEADACHE

no yes yes, this is my main complaint
(if "no" go to the next section Radiology History)

Please describe when you first developed headache/sinus pain:

On which side is your pain more prominent? right
 left
 both

Where is your facial pain/headache most marked?
 at the inner angle of the eye in the cheeks
 around the eye in the back of your head
 on the forehead or eyebrow on your upper teeth
 behind your eyes on your temple
 other (please describe) _____

What is the most appropriate description of this facial pain/headache?
 pressure fullness/heaviness
 throbbing sharp/stabbing
 dull ache cannot be described
 other (please describe) _____

Do you have any facial pain/headache now? no yes

If **yes**, please rate your **current discomfort**

0 1 2 3 4 5 6 7 8 9 10
no pain worst pain possible

- Does your facial pain/headache **worsen** with:
- airplane flight (headache pain only, not ear pain) no yes not sure
 - sinus infections no yes not sure
 - changes in weather no yes not sure
 - position of your head no yes not sure
 - certain foods no yes not sure
 - alcohol consumption no yes not sure
 - tobacco smoke no yes not sure
 - pollution no yes not sure
 - perfumes no yes not sure
 - Menstrual cycle N/A no yes not sure
 - (other irritants) no yes not sure

If yes, please specify _____

- Is your discomfort associated with:
- nausea and/or vomiting? no yes not sure
 - nasal congestion/stuffiness? no yes not sure
 - Have you been diagnosed by another physician no yes
with **migraine headaches**?

If yes, how have you been treated for migraines? _____

How frequently do you have migraine headaches?
 daily
 weekly
 monthly
 annually

- Can you distinguish your migraine headache from sinus-related pain? no yes
- Do you have a family history of migraines? no yes not sure

RADIOLOGY HISTORY

- Have you had prior sinus CT scans? no yes
- Was your last sinus CT scan made after no yes no surgery
previous sinus surgery (ies)?
- Have you had a chest xray in last 2 years no yes

**Please bring a copy of prior CT scans with you to your initial office visit.
(For purposes related to the initial visit, the CT scan report is not as valuable as the actual scans.)*

Past Medical History

Do you HAVE or HAVE YOU BEEN TREATED FOR any of the following? (check all that apply)

- | | | | | |
|--|--|--|---|---|
| <input type="checkbox"/> arthritis | <input type="checkbox"/> hepatitis | <input type="checkbox"/> high blood pressure | <input type="checkbox"/> glaucoma | <input type="checkbox"/> osteoporosis |
| <input type="checkbox"/> asthma | <input type="checkbox"/> heart disease | <input type="checkbox"/> bleeding disorder | <input type="checkbox"/> peptic ulcer disease | <input type="checkbox"/> fibromyalgia |
| <input type="checkbox"/> gastritis | <input type="checkbox"/> tuberculosis (TB) | <input type="checkbox"/> depression | <input type="checkbox"/> immunodeficiency | <input type="checkbox"/> blood thinners |
| <input type="checkbox"/> diabetes | <input type="checkbox"/> mitral valve prolapse | <input type="checkbox"/> kidney disease | <input type="checkbox"/> thyroid disease | <input type="checkbox"/> acid reflux |
| <input type="checkbox"/> seizures | <input type="checkbox"/> meningitis | <input type="checkbox"/> cataracts | <input type="checkbox"/> shingles | |
| <input type="checkbox"/> other (specify) _____ | | | | |

Do you take **aspirin** or any other **anti-inflammatory medication** on a regular basis? no yes
 Have you had head injury associated with loss of consciousness? no yes
 Have you been seen by a neurologist for any reason? no yes
 If **yes**, please check all that apply: headache atypical facial pain seizures head injury other _____

For the following, list in chronological orders all prior surgical procedures including office polypectomies and sinus washouts-lavage.

HOSPITALIZATIONS none

Date	Procedure/reason	Hospital
_____	_____	_____
_____	_____	_____

SURGERIES none

Date	Procedure/reason	Hospital
_____	_____	_____
_____	_____	_____

SINUS or NASAL SURGERY/PROCEDURES none

Date	Procedure/reason	Hospital
_____	_____	_____
_____	_____	_____

****Please obtain a copy of your previous Operative report(s) & Pathology reports to bring to your appointment.***

TRAUMA/BROKEN BONES? no yes, (specify) _____
 Have you ever broken your nose? no yes, (specify and date) _____
RECENT IMMUNIZATIONS: none tetanus flu hepatitis other (specify): _____
TRANSFUSION of BLOOD PRODUCTS: none yes (specify) _____

List **CURRENT MEDICATIONS** (list all meds including aspirin-containing products and all nasal sprays.)

Name	Dose	Frequency	Name	Dose	Frequency

ALLERGIES:

Are you allergic or sensitive to any **medications**? no yes

If yes, please list below - including aspirin-containing products:

Medication allergy/sensitivity	Type of reaction
_____	_____
_____	_____
_____	_____

Do you have symptoms of environmental allergies (listed below)? no yes
 (If "no" go on to the next page on Asthma.)

If yes, do you have any of these allergy symptoms? (check all that apply)

- sneezing fits itchy throat runny nose
- itchy nose itchy eyes
- runny/watery eyes itchy ears clogged ears
- scratchy roof of mouth

Do these symptoms seem to occur with any foods?

- no yes not sure

Are your symptoms constant or intermittent? _____

How long have you had these symptoms?

- less than or equal to 1 year
- more than a year but less than or equal to 2 years
- more than 2 years but less than or equal to 5 years
- more than 5 years but less than or equal to 10 years
- more than 10 years

When are your allergy symptoms most apparent?(check all that apply)

- winter spring
- summer fall all year

Pollen Allergy Symptoms (check all that apply)

- Worse outdoors
- Worse on windy days
- Worse on clear days
- Worse outdoors 7 to 11 am
- Worse with change of temperature
- Worse in warm or cool air
- Better indoors

Dust Allergy Symptoms

- Worse indoors
- Better outdoors
- Worse 30 minutes after retiring
- Worse in cold weather
- Worse when sleeping
- Worse when dusting

Mold Allergy Symptoms

- Worse outdoors from 4 to 9 pm
- Worse on cool evenings
- Worse in low, damp place
- Worse when mowing/play in grass
- Worse on windy days

Do you have pets? Please check all that apply

- Dog inside outside
- Cat inside outside
- Birds
- Gerbils, hamsters, mice, etc.

Are symptoms worse around pets?
 yes no not sure

Feather pillows? Yes No

Age of pillows _____

Age of mattress _____

What type of home to you live in?

- Single house Duplex
- Apartment Hotel
- Trailer

Age of dwelling _____

Have you ever been tested for allergy? ___ no ___ yes ___ not sure
 If yes who was the physician testing _____
 If tested, were you found to have allergy?
 ___ no ___ yes ___ borderline ___ not sure
 If you tested positive for allergy, please list your allergies: ___ can't recall

How long ago was your allergy test? ___ less than 6 months
 ___ 6 months to less than one year
 ___ 1 year to less than 2 years
 ___ 2 years to less than 5 years
 ___ 5 or more years

Were you allergy tested by blood test or skin test?
 ___ blood ___ skin ___ can't recall
 Have you received shots for allergies? ___ no ___ yes ___ not sure

If yes, how long have you been receiving them? ___ less than one year
 ___ more than one year
 ___ no longer receiving

Do you believe the allergy shots helped your condition?
 ___ no ___ yes ___ not sure

If you are no longer receiving shots, about when was your last allergy shot?
 ___ less than or equal to 1 year
 ___ more than a year but less than or equal to 2 years
 ___ more than 2 years but less than or equal to 5 years
 ___ more than 5 years but less than or equal to 10 years
 ___ more than 10 years

For how long did you receive shots? ___ less than or equal to 1 year
 ___ more than 1 year

Any adverse reactions in the past with testing or treatment? ___ Yes ___ No
 If yes, please list reactions

What medications relieve your allergy symptoms?

*** Please bring a copy of your allergy test results to your appointment.**

ASTHMA

___ no ___ yes
 ___ yes, this is my main complaint
 (if "no" go to the next section Family History)

Does your **asthma** flare up in association with:
 discolored nasal drainage/discharge?
 ___ no ___ yes ___ not sure
 nasal congestion?
 ___ no ___ yes ___ not sure
 nasal sinus infections?
 ___ no ___ yes ___ not sure
 exercise or temperature changes?
 ___ no ___ yes ___ not sure

How many asthma attacks have you had during the past year?
0 1 2 3 4 5 6
more than 6

How many emergency visits (to the hospital or doctor's office) did you have for your asthma during the past year?
0 1 2 3 4 more than 4

How many times were you hospitalized overnight for your asthma during the past year?
0 1 2 3 4 more than 4

How many times did you have a breathing tube inserted to help you breath for your asthma (intubated) during the past year?
0 1 2 3 4 more than 4

How many courses of oral steroids (prednisone /medrol) have you taken for your asthma during the past year?
0 1 2 3 4 more than 4
daily/every other day

ASTHMA (Cont)

Have you had spirometry (breathing tests) to assess your asthma?
 ___ no ___ yes
 * Please bring the results of any prior breathing test for our records.

Which medications have you used during the past year for asthma?
 ___ Atrovent
 ___ Oxygen therapy
 ___ Intal/Tilade/Cromolyn
 ___ Oral/Steroids/Medrol/Prednisone
 ___ Proventil/Alupent/Ventolin/Metaprel/Albuterol
 ___ Beclovent/Aerobid/Vanceril
 ___ Symbicort/Advair
 ___ Theophylline/Theodur/Uniphyl
 ___ other (specify): _____

How often have you used asthma inhalers during the past year?
 ___ daily ___ weekly
 ___ monthly ___ rarely
 ___ never

How many times did you use theophylline (Theodur/Slobid) during the past year?
0 1 2 3 4
more than 4 times **daily**

Did your symptoms of asthma first appear before your sinus/ nasal complaints?
 ___ no ___ yes

___ they appeared at same time

FAMILY HISTORY

Please check all that apply to **your family members**:

allergy cystic fibrosis sinus disease asthma
 immunodeficiency high blood pressure bleeding disorder heart disease fertility problems

cancer; If **yes**, list cancer type and relationship of family member _____

Other disease (specify): _____

SOCIAL HISTORY

Current occupation: _____

Have you had a recent change in your home or work environment? no yes

If yes, please describe: _____

Do you smoke or have you ever smoked tobacco on a regular basis? no yes

If yes, how much do/did you smoke? _____ packs/day

How many years have/did you smoke(d)? _____ years

If you have stopped smoking, _____ years ago
how long ago did you stop?

Do you drink alcohol? no yes

If yes, how much do you typically drink? _____ per day/ per week

Did/Do you ever use cocaine? no yes

Have you ever abused any addictive substances? no yes

If yes, what drug(s) were used? _____

When did you last use this/these drug(s)? _____

REVIEW OF SYSTEMS: The following is a list of health care problems/symptoms. Please mark 0-4 below to indicate the severity of each separate problem. After you mark 0-4, you should circle the * if you are being treated by another doctor for that particular problem.

0 this is not a problem

1 this is a symptom but does not affect my quality of life

2 this is a symptom and does affect my quality of life

3 this is a symptom and worsens my quality of life

4 I am not sure if this is a symptom

* I am currently being treated by another doctor for this problem

<u>Ears:</u>		<u>Mouth/Throat:</u>		<u>General:</u>		<u>Nervous System</u>	
Ringing	0 1 2 3 4 *	Dryness	0 1 2 3 4 *	Nausea	0 1 2 3 4 *	Numbness	0 1 2 3 4 *
Dizziness	0 1 2 3 4 *	Difficulty swallowing	0 1 2 3 4 *	Weight gain	0 1 2 3 4 *	Tingling	0 1 2 3 4 *
Vertigo	0 1 2 3 4 *	Pain on swallowing	0 1 2 3 4 *	Weight loss	0 1 2 3 4 *	Fainting	0 1 2 3 4 *
Ear pain	0 1 2 3 4 *	Hoarseness	0 1 2 3 4 *	Fever	0 1 2 3 4 *	Weakness	0 1 2 3 4 *
Ear drainage	0 1 2 3 4 *	Drooling	0 1 2 3 4 *	Chills	0 1 2 3 4 *	Tremor	0 1 2 3 4 *
Hearing loss	0 1 2 3 4 *	Choking on solid/liquids	0 1 2 3 4 *	Night sweats	0 1 2 3 4 *		
<u>GI Tract</u>		Lumps in neck	0 1 2 3 4 *	Fatigue	0 1 2 3 4 *	<u>Eyes</u>	
Indigestion	0 1 2 3 4 *	<u>Sleep Disturbance</u>		<u>Cardiovascular</u>		Decreased vision	0 1 2 3 4 *
Heartburn	0 1 2 3 4 *	Loud snoring	0 1 2 3 4 *	Murmur	0 1 2 3 4 *	Double vision	0 1 2 3 4 *
Vomiting	0 1 2 3 4 *	Daytime sleepiness	0 1 2 3 4 *	Palpitations	0 1 2 3 4 *	Clouded vision	0 1 2 3 4 *
Changed Stool	0 1 2 3 4 *	Difficulty falling asleep	0 1 2 3 4 *	Chest pain/pressure	0 1 2 3 4 *	Eye Pain	0 1 2 3 4 *
Diarrhea	0 1 2 3 4 *	Difficulty staying asleep	0 1 2 3 4 *	<u>Pulmonary</u>		Abnormal tearing	0 1 2 3 4 *
Constipation	0 1 2 3 4 *	Stoppage of breathing	0 1 2 3 4 *	Shortness of breath	0 1 2 3 4 *	<u>Endocrine</u>	
Abdominal pain	0 1 2 3 4 *	Arise not feeling rested	0 1 2 3 4 *	Wheezing	0 1 2 3 4 *	Heat/cold intolerance	0 1 2 3 4 *
<u>Hematology</u>		<u>Urinary tract</u>		Chest tightness	0 1 2 3 4 *	Excessive thirst	0 1 2 3 4 *
Easy bruising	0 1 2 3 4 *	Burning	0 1 2 3 4 *	Productive cough	0 1 2 3 4 *	Irregular menses	0 1 2 3 4 *
Prolonged bleeding	0 1 2 3 4 *	Frequency	0 1 2 3 4 *	Pulmonary emboli	0 1 2 3 4 *	<u>Psychological</u>	
Transfusions	0 1 2 3 4 *	Color change	0 1 2 3 4 *	<u>Rheumatology</u>		Depression	0 1 2 3 4 *
Blood clots/ emboli	0 1 2 3 4 *	Interstitial cystitis	0 1 2 3 4 *	Joint pain	0 1 2 3 4 *	Anxiety/ Claustrophobia	0 1 2 3 4 *
				Sore tendons/muscles	0 1 2 3 4 *	Schizophrenia	0 1 2 3 4 *

I have completed this 9 page questionnaire accurately and to the best of my ability:

X _____

Date _____