



# 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

<b>SYMPTOM</b>						<b>SYMPTOM</b>								
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			
<b>How long have you had this symptom?</b>	<b>Sinus Infection</b>		<b>Facial Pressure, Pain, Headache</b>		<b>Nasal Blockage, Stuffiness</b>		<b>Runny Nose/ Post-nasal drip</b>		<b>Nasal Bleeding</b>		<b>Altered Smell</b>		<b>Asthma</b>	
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 <b>Enter the number in the boxes below</b>	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

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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

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What medications relieve your allergy symptoms?

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**\* 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): \_\_\_\_\_

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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 \_\_\_\_\_