LAWRENCE OTOLARYNGOLOGY ASSOCIATES, LLC
Tonsil Questionnaire
Dr. Robert Dinsdale

NAME _____ DATE_____

1) How do you know you or your child have tonsil problems? **(Circle all that apply)**

A) Sore throat B) Fever

C) Fatigue D) Difficulty swallowing

E) Snoring **without** stopping breathing F) Snoring **with** stopping breathing

G) Bad breath H) White patches on tonsils

I) Spit out foul-smelling solid material from throat

J) Tonsils are big K) Other _____

2) How many times in the last year has there been treatment for tonsil problems? _____

3) Any hospitalizations for tonsil problems? Yes / No

4) On a scale of 1-10 with 10 being the worst, where would you rate these tonsil problems?

1 2 3 4 5 6 7 8 9 10

5) About how many days of school or work have been missed in the last year because of these problems? 0 1-5 6-10 more than 10

6) Do the tonsil problems affect your/your child's speech or voice quality? Yes / No

7) Please list the antibiotics used for tonsil problems in the last year:

	Name of Medication	**Date Started**	**Date Ended**
A.	_____	_____	_____
B.	_____	_____	_____
C.	_____	_____	_____
D.	_____	_____	_____
E.	_____	_____	_____
F.	_____	_____	_____
G.	_____	_____	_____
H.	_____	_____	_____

8) Any mouth breathing? Yes/ No

9) Do any relatives have problems with easy bruising, excessive bleeding after surgery, or bleeding several days after losing a tooth? Yes / No

10) Do any relatives have sickle cell? Yes / No