# Northwest Sinus Center

## Director: Ryan P. Gallivan, MD

central oregon
EAR | NOSE | THROAT

# New Patient Questionnaire

| Name | MRN | DOB | Date |
|---|---|---|---|
| | | | |

Telephone
H W M

Pharmacy
Name Telephone

How did you hear about us?
- ❑ Sent by another physician (If so, please give name below.)
- ❑ Sent by a friend
- ❑ Internet search
- ❑ Other (Specify)

Physician #1 (☐ sent by this physician)
Name Fax Telephone
Address City, State Zip

Physician #2 (☐ sent by this physician)
Name Fax Telephone
Address City, State Zip

**Important Note on Medical Records and Previous Imaging**

Please be sure to bring your previous medical records. In particular, previous CT scans and MRI scans of the nose and sinuses are very important. Please try to obtain the actual films (not just the radiology reports).

**START HERE:**

**What symptom gives you the most trouble?**

**Nasal Symptom Inventory**
*The following rating scale will be used to complete the questions:*

| Scale | | Severity Definition |
|---|---|---|
| 0 | **None** | *Absent-NO symptom evident* |
| 1 | **Mild** | *Symptom clearly PRESENT but minimal awareness; easily tolerated* |
| 2 | **Moderate** | *Definite awareness of symptom that is bothersome, but tolerable* |
| 3 | **Severe** | *Symptom is hard to tolerate; interferes with activities of daily living and/or sleeping* |

***Using the rating scale above, please rate the following symptoms according to how you feel right now.***

| | None | Mild | Moderate | Severe |
|---|---|---|---|---|
| **Facial or sinus pressure** (pressure or fullness in the area behind the eyes, cheeks, forehead, or sinuses) | ☐ | ☐ | ☐ | ☐ |
| **Facial or sinus pain** (pain in the area around the eyes, cheeks, forehead) | ☐ | ☐ | ☐ | ☐ |
| **Headache** (dull to intense, throbbing pain in head) | ☐ | ☐ | ☐ | ☐ |
| **Nasal congestion** (stopped up or stuffy nose) | ☐ | ☐ | ☐ | ☐ |
| **Nasal obstruction** (inability to move air through the nose) | ☐ | ☐ | ☐ | ☐ |
| **Post-nasal drip** (sinus drainage in the back of the throat) | ☐ | ☐ | ☐ | ☐ |
| **Clear nasal discharge** (nasal mucus that is clear) | ☐ | ☐ | ☐ | ☐ |
| **Discolored nasal discharge** (nasal mucus that is green, yellow, and/or brown) | ☐ | ☐ | ☐ | ☐ |
| **Itchy nose/eyes/throat** (sensation of itchiness in the nose, eyes and/or throat) | ☐ | ☐ | ☐ | ☐ |
| **Nose bleeds** (bleeding, not bloody mucus, from the nose) | ☐ | ☐ | ☐ | ☐ |
| **Tiredness** (feeling worn out or drained due to chronic sinusitis) | ☐ | ☐ | ☐ | ☐ |
| **Wheezing** (whistling sound from breathing, associated with chest tightness) | ☐ | ☐ | ☐ | ☐ |
| **Cough** | ☐ | ☐ | ☐ | ☐ |



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**Sino-Nasal Outcome Test (SNOT-22)**

*Below you will find a list of symptoms and social/emotional consequences of your rhinosinusitis. We would like to know more about these problems and would appreciate your answering the following questions to the best of your ability. There are no right or wrong answers, and only you can provide us with this information. Please rate your problems as they have been over the past two weeks. Thank you for your participation. Do not hesitate to ask for assistance if necessary.*

***Important:*** *Please mark the most important items affecting your health (maximum of 5 items).*

| Considering how severe the problem is when you experience it and how frequently it happens, please rate each item below on how "bad" it is by circling the number that corresponds with how you feel using this scale: | No Problem | Very Mild Problem | Mild or Slight Problem | Moderate Problem | Severe Problem | Problem as Bad as It Can Be | | Most Important Items |
|---|---|---|---|---|---|---|---|---|
| 1. Need to blow nose | 0 | 1 | 2 | 3 | 4 | 5 | | O |
| 2. Sneezing | 0 | 1 | 2 | 3 | 4 | 5 | | O |
| 3. Runny nose | 0 | 1 | 2 | 3 | 4 | 5 | | O |
| 4. Cough | 0 | 1 | 2 | 3 | 4 | 5 | | O |
| 5. Post-nasal discharge (dripping at the back of your nose) | 0 | 1 | 2 | 3 | 4 | 5 | | O |
| 6. Thick nasal discharge | 0 | 1 | 2 | 3 | 4 | 5 | | O |
| 7. Ear fullness | 0 | 1 | 2 | 3 | 4 | 5 | | O |
| 8. Dizziness | 0 | 1 | 2 | 3 | 4 | 5 | | O |
| 9. Ear pain | 0 | 1 | 2 | 3 | 4 | 5 | | O |
| 10. Facial pain/pressure | 0 | 1 | 2 | 3 | 4 | 5 | | O |
| 11. Difficulty falling asleep | 0 | 1 | 2 | 3 | 4 | 5 | | O |
| 12. Wake up at night | 0 | 1 | 2 | 3 | 4 | 5 | | O |
| 13. Lack of a good night's sleep | 0 | 1 | 2 | 3 | 4 | 5 | | O |
| 14. Wake up tired | 0 | 1 | 2 | 3 | 4 | 5 | | O |
| 15. Fatigue | 0 | 1 | 2 | 3 | 4 | 5 | | O |
| 16. Reduced productivity | 0 | 1 | 2 | 3 | 4 | 5 | | O |
| 17. Reduced concentration | 0 | 1 | 2 | 3 | 4 | 5 | | O |
| 18. Frustrated/restless/irritable | 0 | 1 | 2 | 3 | 4 | 5 | | O |
| 19. Sad | 0 | 1 | 2 | 3 | 4 | 5 | | O |
| 20. Embarrassed | 0 | 1 | 2 | 3 | 4 | 5 | | O |
| 21. Sense of taste/smell | 0 | 1 | 2 | 3 | 4 | 5 | | O |
| 22. Blockage/congestion of nose | 0 | 1 | 2 | 3 | 4 | 5 | | O |



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Do you have RECURRENT or CHRONIC NASAL/SINUS INFECTIONS?

___ NO ___ YES ___ Yes, this is my main complaint

IF NO GO TO THE NEXT SECTION, Nasal Congestion, (Below)

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

Have you used any of these other treatments? (check all that apply)

____ humidifier ____ saline nasal spray ____ air purifier
____ steam inhalation ____ other (please describe: _____)

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Do you have NASAL CONGESTION or BLOCKAGE (STUFFINESS)?

____ NO ____ YES ____ YES, this is my main complaint

IF NO GO TO THE NEXT SECTION, SMELL or TASTE disturbance (right column of this page)

Do you have this blockage/congestion now? ____ no ____ yes
Which side of your nose is most often affected? ____ right
____ left
____ both

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 | ____ no | ____ yes | ____ not sure |

(please specify) _____

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Do you have a change in your sense of SMELL or TASTE?

____ NO ____ YES ____ YES, this is my main complaint

IF NO GO TO THE NEXT SECTION, Nasal Discharge, (Next Page)

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



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Do you have 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 (right column this page)

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 describes the typical appearance(s) of your drainage:

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

Is the drainage thin and water-like, or thicker like mucus?

____ thin____ thick____both

If thin, does it have a salty taste?

____ no____ yes___not sure

If thin, does it appear after bending, lifting, or staining?

____ no____ yes___not sure

Do you have NASAL BLEEDING from your nose?

____ NO ____ YES ____ YES, this is my main complaint

IF NO GO TO THE NEXT SECTION, Facial pain/Headache (next page)

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 heaving 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? _____



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Do you have FACIAL PAIN/PRESSURE or HEADACHE?

____ NO ____ YES ____ YES, this is my main complaint

IF NO GO TO THE NEXT SECTION, Past Medical HISTORY (page 7)

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
___ around the eye
___ on the forehead or eyebrow
___ behind your eyes
___ other (please describe) _____
___ in the cheeks
___ in the back of your head
___ on your upper teeth
___ on your temple

What is the most appropriate description of this facial pain/headache?

___ pressure
___ throbbing
___ dull ache
___ other (please describe) _____
___ fullness/heaviness
___ sharp/stabbing
___ cannot be described

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 |

other irritants (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 with migraine headaches, by another physician?
___ no ___ yes

If yes, please answer the following questions.

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



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**General**

How frequently do you have sinus and nasal symptoms?
O Continuously
O This is the first episode.
O 3 times/year
O 4-6 times per year
O Monthly
O Weekly
O Daily
O Constantly

Do your symptoms improve between episodes?
O Yes, they completely improve
O No, they never improve
O Sometimes, they improve
O They improve partially

How often do your baseline symptoms get worse?
O Never (The symptoms are always the same.)
O 1-3 times/year
O 4-6 times per year
O More than 6 times per year

Which best describes your sense of smell?
O No problem with sense of smell
O Diminished sense of smell
O Loss of smell
O Detect bad odor

Have you ever had a sinus CT or MRI scan?
O Yes
O No
*If yes, please provide details (including dates) below.*

Have you ever had a sinus or nasal surgery?
O Yes
O No
*If yes, please provide details (including dates) below.*

*Details*

**Allergy Page**

Do you have any of these allergy symptoms?
O Sneezing fits
O Itchy ears
O Itchy eyes
O Itchy nose
O Runny nose
O Itchy throat
O Runny/watery eyes
O Scratchy roof of your mouth

When are your allergy symptoms most apparent?
O Spring
O Summer
O Fall
O Winter
O Continuously throughout the year

Have you ever been tested for allergy?
O Never
O I have had skin testing for allergy.
O I have had blood testing for allergy.

Have you received allergy shots?
O Never
O Yes, and they helped a great deal.
O Yes, and they helped somewhat.
O Yes, and they did nothing.

Do you take aspirin or any other anti-inflammatory medication on a regular basis?
O Yes
O No

Are you allergic to aspirin or Ibuprofen products?
O Yes
O No

**Asthma**

Do you have asthma?
O Yes
O No

If yes, what do you take for your asthma?
O Asthma inhalers
O Nebulizer treatments
O Oral steroids
O Theophylline
O Other

**Trauma**

Have you ever broken your nose?
O Yes
O No

Have you ever sustained other facial and/or head injuries?
O Yes
O No



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**Rhinosinusitis Disability Index (RSDI)**

***Instructions:*** *This 30-question survey was designed to help understand the severity of your disease and how it can affect every aspect of your daily life. For each of the following questions, please mark in the one circle that best describes your answer. If you are unsure about how to answer a question, please give the best answer you can.*

| | | Never | Almost Never | Sometimes | Almost Always | Always |
|---|---|---|---|---|---|---|
| F1 | Because of my problem I feel handicapped | O | O | O | O | O |
| F2 | Because of my problems I feel restricted in performance of my routine daily activities | O | O | O | O | O |
| F3 | Because of my problem I restrict my recreational activities | O | O | O | O | O |
| F4 | Because of my problem I feel frustrated | O | O | O | O | O |
| F5 | Because of my problem I feel fatigued | O | O | O | O | O |
| P6 | Because of my problem I do not sleep well | O | O | O | O | O |
| P7 | I have difficulty with exertion due to my nasal obstruction | O | O | O | O | O |
| P8 | I am inconvenienced by my chronic runny nose | O | O | O | O | O |
| P9 | The pain or pressure in my face makes it difficult for me to concentrate | O | O | O | O | O |
| P10 | The pain in my eyes makes it difficult for me to read | O | O | O | O | O |
| P11 | I have difficulty stooping over to lift objects due to face pressure | O | O | O | O | O |
| E12 | Because of my problem I feel stressed in relationships with friends and family | O | O | O | O | O |
| E13 | Because of my problem I avoid traveling | O | O | O | O | O |
| E14 | Because of my problem I feel confused | O | O | O | O | O |
| E15 | Because of my problem I have difficulty paying attention | O | O | O | O | O |
| E16 | Because of my problem I avoid being around people | O | O | O | O | O |
| E17 | Because of my problem I am frequently angry | O | O | O | O | O |
| E18 | Because of my problem I do not like to socialize | O | O | O | O | O |
| E19 | Because of my problem I frequently feel tense | O | O | O | O | O |
| P20 | Food does not taste good because of my change in smell | O | O | O | O | O |
| E21 | Because of my problem I frequently feel irritable | O | O | O | O | O |
| P22 | Because of my problem I have difficulty with strenuous yard work and housework | O | O | O | O | O |
| F23 | Because of my problem I miss work or social activities | O | O | O | O | O |
| P24 | My frequent sniffing is irritating to my friends and family | O | O | O | O | O |
| P25 | Straining increases or worsens my problem | O | O | O | O | O |
| E26 | Because of my problem I am depressed | O | O | O | O | O |
| E27 | My problem places stress on my relationship with members of my family or friends | O | O | O | O | O |
| F28 | My outlook on the world is affected by my problem | O | O | O | O | O |
| F29 | Because of my problem I find it difficult to focus my attention away from my problem and on other things | O | O | O | O | O |
| P30 | My sexual activity is affected by my problem | O | O | O | O | O |



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**Previous Treatments**

Which antibiotics have you received over the past year?
O Amox and/or PCN.
O Amox/clav (Augmentin)
O Azithromycin (Zithromax, Z-pak)
O Cefadroxil (Duricef)
O Cefdinir (Omnicef)
O Cefpodoxime (Vantin)
O Cefprozil (Cefzil)
O Cefuroxime (Ceftin)
O Cephalexin (Keflex)
O Ciprofloxacin (Cipro
O Clarithromycin (Biaxin)
O Erythromycin
O Gatifloxacin (Tequin)
O Levofloxacin (Levaquin)
O Loracarbef (Lorabid)
O Moxifloxacin (Avelox)
O SMP/TMX (Bactrim, Sulfa)
O Telithromycin.
O IV antibiotics
O Others
O Unknown
O None

Which antihistamines have you received over the past year?
O Cetirizine (Zyrtec)
O Cetirizine/decongestant (Zyrtec-D)
O Desloratadine (Clarinex)
O Desloratadine/decongestant (Clarinex-D)
O Diphenhydramine (Benadryl)
O Fexofenadine (Allegra)
O Fexofenadine/decongestant (Allegra-D)
O Levocetirizine (Zyzal)
O Loratadine (Claritin)
O Loratadine/decongestant (Claritin-D)
O Others
O Unknown
O None

Which nasal sprays have you used over the past year?
O Budesonide (Rhinocort)
O Ciclesonide (Omnaris)
O Flunisolide (Nasarel)
O Fluticasone furoate (Veramyst)
O Fluticasone propionate (Flonase)
O Mometasone (Nasonex)
O Triamcinolone (Nasacort)
O Oxymetazoline (Afrin)
O Azelastine (Astelin)
O Olopatadine (Patanase)
O Ipratropium bromide (Atrovent)
O Others
O Unknown
O None

What other treatments have you used over the past year?
O Montelukast (Singulair)
O Antifungal treatments
O Guaifenesin OTC (Mucinex)
O Nasal saline sprays
O Nasal saline irrigations
O Oral decongestants
O Systemic steroids
O Topical antibiotic irrigations/treatments
O Others
O Unknown
O None



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**Review of Systems**

*The following is a list of common symptoms and health problems. Please review the list and indicate with a check mark which symptoms and health problems that you are experiencing.*

| | Yes | No | Treated by another physician |
|---|---|---|---|
| **General** | | | |
| Nausea | O | O | O |
| Weight gain | O | O | O |
| Weight loss | O | O | O |
| Fevers/chills | O | O | O |
| **Ears, Nose & Throat** | | | |
| Hoarseness | O | O | O |
| Hearing loss | O | O | O |
| Draining ear | O | O | O |
| Vertigo | O | O | O |
| Loud snoring | O | O | O |
| Daytime sleepiness | O | O | O |
| Mouth sores | O | O | O |
| Tooth problems | O | O | O |
| Painful/difficult swallowing | O | O | O |
| Ringing in the ears | O | O | O |
| **Eyes** | | | |
| Double vision | O | O | O |
| Blurry vision | O | O | O |
| **Cardiac** | | | |
| Chest pain | O | O | O |
| Short of breath | O | O | O |
| **Respiratory** | | | |
| Wheezing | O | O | O |
| Cough | O | O | O |

| | Yes | No | Treated by another physician |
|---|---|---|---|
| **Gastro-intestinal** | | | |
| Heartburn | O | O | O |
| Belly pain | O | O | O |
| Diarrhea | O | O | O |
| Constipation | O | O | O |
| Vomiting | O | O | O |
| **Skin** | | | |
| Rashes | O | O | O |
| Ulcers | O | O | O |
| **Musculo-skeletal** | | | |
| Muscle pain | O | O | O |
| Muscle weakness | O | O | O |
| **Endocrine** | | | |
| Cold intolerance | O | O | O |
| Heat intolerance | O | O | O |
| Excessive thirst | O | O | O |
| **Hematologic** | | | |
| Anemia | O | O | O |
| Bleeding | O | O | O |
| Bruising | O | O | O |
| **Neurological** | | | |
| Seizures | O | O | O |
| **Psychiatric** | | | |
| Depression | O | O | O |
| Anxiety | O | O | O |



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## Past History

Do you have any of the following medical problems?

O Arthritis
O Asthma
O Bleeding disorder
O Cataracts
O Chronic fatigue syndrome
O Depression
O Diabetes
O Fibromyalgia
O Gastritis
O Glaucoma
O Hepatitis
O High blood pressure
O Heart disease
O Immunodeficiency
O Kidney disease
O Meningitis
O Migraine headache
O Mitral valve prolapse
O Peptic ulcer disease
O Seizures
O Thyroid disease
O Tuberculosis (TB)

Please list your previous surgical procedures.

Please list your previous hospitalizations.

Do you have any other medical problems not listed above?
O Yes
O No
*(If yes, please give details.)*

Please list your current medications.

Are you allergic to any medications?
O Yes
O No
*(If yes, please give details.)*

## Family History

Do any of your family members have any of the following conditions?

O Allergy
O Asthma
O Bleeding disorder
O Cancer
O Cystic fibrosis
O Heart disease
O Immunodeficiency

## Social History

What is your occupation?

Have you had any recent change in your home or work environment?
O Yes
O No
Details

Do you smoke?
O Yes
O No
Details

Do you drink alcoholic beverages?
O Yes
O No
Details

Have you ever used cocaine or other illicit substances?
O Yes
O No.
Details