Northwest Sinus Center

Director: Ryan P. Gallivan, MD

central oregon
EAR | NOSE | THROAT

Established 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?

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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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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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Other Treatments

Have you seen another physician since your last visit? If Yes, please provide details.

O Yes
O No

Medications

Please list your current medications.

Please list any other medications that you have taken since your last visit, but are not longer using.

Are you allergic to any medications?

O Yes *Details*
O No
(If yes, please give details.)

Comments