Patient Name: _____ DOB: _____ Today's Date: _____

Allergy & Sinus Questionnaire

All Patients:

1. Have you tried or are you using any allergy medications?
   - o Claritin, Zyrtec, Allegra, Benadryl
   - o Flonase, Nasacort, Nasonex, Veramyst
   - o Astelin, Astepro, Patanase
   - o Sudafed, Claritin D, Zyrtec D, Allegra D
   - o Mucinex
   - o Singulair
   - o Other _____
2. How often do you need these medications?
   - o Daily
   - o 2-3 times a month
   - o With seasonal flares only
   - o As needed only
3. Have you had a sinus infection within the last 3 months?
   - o YES
   - o NO

   If Yes, did you seek treatment? YES NO

   If Yes, where did you seek treatment?_____

   Did you take any medications to treat the sinus infection? YES NO
   If Yes, please list:_____
4. Have you had a CT Scan of the Sinuses within the last 12 months?
   - o YES
   - o No

   If Yes, where was it done?_____

Allergy Drop Patients:

1. When did you start allergy drops?

   _____
2. Have you missed any doses?

   _____

   _____
3. Do you have any symptoms after allergy drops?
   YES NO
   If Yes, explain:

   _____

   _____

Allergy Shots Patients:

1. Where do you get injections?
   - o In our office
   - o Another Medical Center/DR Office
   - o Home treatment
2. How often do you get your allergy shots?
   - o Weekly, 1-2 times
   - o Every 2 weeks
   - o Every 3 weeks
   - o Once a month
3. Do you have any site reactions after injections?
   - o None
   - o Redness and itching
   - o Small bumps (dime size and under)
   - o Large bumps (quarter size or bigger)
4. Do you have any symptoms after allergy injections? YES NO
   If Yes, explain:

   _____

   _____

ALL PATIENTS CONTINUE ON BACK

Patient Name: _____ DOB: _____ Today's Date: _____

Sino-Nasal Outcome Test (SNOT – 20)

1. Consider 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 feels. 2. Please mark the most important items affecting your health (maximum of 5 items).	No problem	Very mild problem	Mild or slight problem	Moderate problem	Severe problem	Problem as bad as it can be		5 most important
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 drainage	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 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