

Richard W. Waguespack, MD

**NASAL & SINUS QUESTIONNAIRE** Patient's name: \_\_\_\_\_  
Date: \_\_\_\_\_

**Please help us to obtain your Nasal & Sinus history by printing and completing this form:**

How long have you had this problem? \_\_\_\_\_

Please circle response:

Yes No Do you know anything that may have caused your problem? If yes, what? \_\_\_\_\_

Right Left Nasal congestion or stuffiness?

Yes No Do you have loss of or a decreased sense of smell?

Yes No Facial pain? Where is it located? \_\_\_\_\_

Yes No Do you regularly or daily use **nose drops**? What type? \_\_\_\_\_

Yes No Do you have **nasal drainage** or post-nasal drip? What type? Thin & watery Thick Clear  
White/yellow/green (pus-like) Bloody What time of day is it worse? \_\_\_\_\_

Yes No Do you have **allergies**? If yes, when were you tested? \_\_\_\_\_

How was the testing done?  skin tests  blood tests What were the results? \_\_\_\_\_

Did you take shots? Yes No If shots were taken, did they help? Yes No

Are you still taking them? Yes No If no, why were they stopped? \_\_\_\_\_

Yes No Do you have a strong **family history** to suggest allergy? \_\_\_\_\_

Yes No Have you had nasal or sinus **surgery** in the past? If yes, give details below.  
\_\_\_\_\_  
\_\_\_\_\_

Yes No Have you had a **sinus CT scan or x-rays** lately? If yes, when and where were they done and what did they show? \_\_\_\_\_

Yes No Are your symptoms made worse by changes in the weather, temperature or humidity?

Yes No Do your symptoms vary with the **time of year**? When are they worst? \_\_\_\_\_

Yes No Do you **smoke** or are you exposed to chemicals, excessive dust or irritants? If you smoke, how many packs each day? \_\_\_\_\_ For how many years? \_\_\_\_\_

What other treatments have you had in the past (including surgery) for this condition? None  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please list **all medicines and treatments** you are using now for your problem. None  
\_\_\_\_\_  
\_\_\_\_\_

Comments: