PATIENT: _____ **Date:**_____

SINUS HISTORY

Have you had a sinus infection in the past year?* ○ No ○ Yes
If yes, how many? ○ 0 to 1 ○ 2 to 4 ○ >5

Have you taken an antibiotic in the last year? ○ No ○ Yes

If so, what kind? _____
How many times? ○ 0 to 1 ○ 2 to 4 ○ >5

Do you have sinus headaches (not migraine)? ○ No ○ Yes
If yes. ___times per (circle one)○ week○ month ○ year

Worse on: ○ Right ○ Left ○ Both sides
○ Cheeks ○ Back of Head

Have you had aspirin allergy? ○ No ○ Yes

Do you have loss of smell? ○ No ○ Yes

DO you have nasal airway obstruction? * ○ No ○ Yes
If yes, grade from 0 to 4+: _____ (0 = no blockage;
4+ = completely blocked on 1 or both sides)

Do you have postnasal drip?* ○ No ○ Yes
If yes, grade from 0 to 4+: _____ (4+ = most)

Do you have any allergies?* ○ No ○ Yes
If yes, what? : _____

Have you been tested for allergies?* ○ No ○ Yes

Have you ever taken allergy shots?* ○ No ○ Yes
If yes, when _____ and for how long _____

Have you had drainage from the nose?* ○ No ○ Yes

Have you had sinus surgery? ○ No ○ Yes
If yes, how many _____ and when _____

Do you smoke? ○ No ○ Yes

ENVIRONMENTAL HISTORY:

Has the furnace or air conditioner location in your home ever been damp?	No ○	Yes ○
Is the heater or air conditioner located in a dirt crawl space?	No ○	Yes ○
If yes, is the crawl space damp?	No ○	Yes ○
Is the heater located in the attic with blown-in insulation?	No ○	Yes ○
Do you have a humidifier in the central furnace?	No ○	Yes ○
Have you ever had a leak or flood anywhere in your home?	No ○	Yes ○
Do you ever notice a musty smell in the house?	No ○	Yes ○
Have you ever noticed any mold in the house (other than the bathroom?	No ○	Yes ○
Do you or co-workers feel bad at the office?	No ○	Yes ○
Do you feel better away from home or away from the office?	No ○	Yes ○
Do you feel better if you go to the beach or other clean air space?	No ○	Yes ○
Do you have pets in the home?	No ○	Yes ○
If yes, which?	No ○	Yes ○
Do you sleep with pets?	No ○	Yes ○
Do you have a front loader washer?	No ○	Yes ○
Has your car ever been wet/leaked on the inside	No ○	Yes ○
Do you drive a BMW?	No ○	Yes ○

A. Sinus and upper respiratory symptoms:		
1. Asthma *	No ○	Yes ○
2. Bronchitis *	No ○	Yes ○
B. General symptoms:		
1. Fatigue grade 0-10 0=can't get out of bed 10=can walk 5 miles	No ○	Yes ○
2. Abdominal pain	No ○	Yes ○

3. Allergic complex to foods *	No	Yes
4. Attention Deficit Disorder (ADD) *	No	Yes
5. Constipation *	No	Yes
6. Diabetes *	No	Yes
7. Diarrhea	No	Yes
8. Bloating and/or gas *	No	Yes
9. Stomach Pain *	No	Yes
10. Gut Problems (Enteropathy) *	No	Yes
11. Leakey Gut Syndrome *	No	Yes
12. Gluten Sensitivity *	No	Yes
13.Loss of protein in gut *	No	Yes
14.Gastritis (Stomach inflammation) *	No	Yes
15. Cloitis (bowel inflammation)	No	Yes
16. Hyperactivity *	No	Yes
17. Hypoglycemia (low blood sugar) *	No	Yes
18. Interstitial cystitis (bladder inflammation) *	No	Yes
19. Migraine *	No	Yes
20. Obesity *	No	Yes
21. Muscle and/or joint pain/fibromyalgia *	No	Yes
22. Weakness *	No	Yes
23. Memory loss and/or problems concentrating	No	Yes
24. Irritable bowel syndrome *	No	Yes
25. Blurred vision *	No	Yes
26. Chest tightness *	No	Yes

27. Insomnia	No	Yes
28. Numbness/tingling	No	Yes
29. Laryngitis *	No	Yes
30. Anxiety, depression, or irritability?	No	Yes
31. Skin rashes *	No	Yes
32. Psoriasis *	No	Yes
33. Eczema *	No	Yes
34. Hives *	No	Yes
35. Urticaria (itching) *	No	Yes
36. Tremors/seizures	No	Yes
37. Shortness of breath	No	Yes
38. Cancer	No	Yes
39. Lymphoma	No	Yes
40. Leukemia	No	Yes
41. Lupus	No	Yes
42. Esophageal acid reflux *	No	Yes
C. Female Disorder Symptoms (Please answer only if you feel comfortable giving this information):		
1. Infertility If yes, did you ever have a normal pregnancy?	No	Yes
2. Polycystic ovary	No	Yes
3. Endometriosis	No	Yes
4. Tubal blockage	No	Yes
5. Hormonal or ovulation difficulty	No	Yes

Date:_____ Signed:_____