Crystal Community ENT Symptom Assessment Worksheet

Name: _____

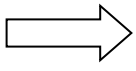
Today's Date:_____DOB: _____ Gender: ▪ Male ▪ Female

Below you will find a list of symptoms and social/emotional consequences of your rhino sinusitis. 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. Rate your symptoms as they have been over the past two weeks giving consideration to the severity and frequency of the problem when it occurs. Please rate each item below by

▪ Baseline ▪ Post-procedure _____ weeks

	No Problem	Very Mild	Mild to Moderate	Moderate	Severe	As Bad as it can be	5 most important items	Subtotal score
1. Need to blow nose	0	1	2	3	4	5		
2. Sneezing	0	1	2	3	4	5		
3. Runny Nose	0	1	2	3	4	5		
4. Cough	0	1	2	3	4	5		
5. Post-nasal discharge	0	1	2	3	4	5		
6. Thick nasal discharge	0	1	2	3	4	5		
7. Ear fullness	0	1	2	3	4	5		
8. Dizziness	0	1	2	3	4	5		
9. Ear Pain	0	1	2	3	4	5		
10. Facial pain/pressure	0	1	2	3	4	5		
11. Difficulty falling asleep	0	1	2	3	4	5		
12. Wake up prematurely	0	1	2	3	4	5		
13. Poor quality of sleep	0	1	2	3	4	5		
14. Wake up tired	0	1	2	3	4	5		
15. Fatigue throughout the day	0	1	2	3	4	5		
16. Reduced productivity	0	1	2	3	4	5		
17. Reduced concentration	0	1	2	3	4	5		
18. Restless/irritable/agitated	0	1	2	3	4	5		
19. Sad	0	1	2	3	4	5		
20. Embarrassed	0	1	2	3	4	5		

Total Score _____



Please fill out other side

Patient Name:_____ Date:_____

Which of the following symptoms currently bother you? (Mark all that apply)

□ Facial pain/pressure
□ Facial congestion/fullness
□ Nasal obstruction/blockage
□ Headache □ Bad breath
□ Fatigue □ Dental pain
□ Sneezing □ Runny nose
□ Watery eyes □ Itchy eyes
□ Dark circles under the eyes/puffy eyes

□ Decreased sense of smell
□ Nasal discharge/pus/discolored postnasal drainage
□ Fever
□ Cough
□ Ear pain/pressure/fullness
□ Itchy nose
□ Itchy ears □ Other _____

The above symptoms are: □ Intermittent □ Continuous

In the list above, circle your main complaint.

1. How many sinus infections have you been treated for in the last year? _____
2. Please name the medications have you taken for your symptoms.
   Antibiotics: _____
   Nasal sprays: _____
   Other oral pills: _____
   Please circle allergy medication you have taken in the past or are currently taking:
   Claritin Clarinex Zyrtec Allegra Astelin Flonase Rhinocort Nasonex Nasocort Nasarel Atrovent
3. Have you ever taken oral steroids (Medrol, Prednisone)? □Yes □No
4. Have you had sinus surgery? □ Yes □No
   If so, please list the dates and what procedure(s) you were told was/were performed:
   _____
5. Do you have asthma? □Yes □No
6. Have you been told you have nasal/sinus polyps? □ Yes □No
7. Are you allergic to/sensitive to aspirin? □Yes □No
8. Do you smoke? □ Yes □No
9. Do you have environmental allergies? (e.g., hayfever, seasonal allergies, dust) □ Yes □ No
10. If so, have you undergone allergy testing? □ Yes □ No
    Please list your sensitivities/allergies. _____
11. How have your allergies been treated? **Allergy shots** □Yes □No **Medications** □Yes □No
12. Did your environment change prior to the onset of your problems? □Yes □No
    If so, in what way? (e.g., house move, new office) _____
13. Are you exposed to chemicals in your occupation or have you noticed an increase in nasal or sinus symptoms around certain chemicals/aromas? □ Yes □ No

If yes, please list your sensitivities_____