**University of Texas Medical School at Houston**

**Department of Otorhinolaryngology- Head & Neck Surgery**

**Texas Sinus Institute**

[***www.ut-ent.org***](http://www.ut-ent.org/)

**New Patient Questionnaire**

Rev. 2014-07-19 FINAL REV **Page 1 of 7 SCAN THIS PAGE.**



|  |  |  |  |
| --- | --- | --- | --- |
| 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
* UT and/or TSI reputation
* 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); images on CD-ROM are preferable.

## START HERE:

**What symptom gives you the most trouble?**

**Nasal Symptom Inventory Page 2 of 7**

**DO NOT SCAN.**

*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** |  |  |  |
| **Sense of smell**(reduced sense of smell or detection of bad odor) |  |  |  |

# Next page

## Sino-Nasal Outcome Test (SNOT-22) Page 3 of 7

**SCAN THIS PAGE.**

*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 |  |  |
| 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 (dripping at the back of your nose) | 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 at night | 0 | 1 | 2 | 3 | 4 | 5 |  |  |
| 13. Lack of a good night’s sleep | 0 | 1 | 2 | 3 | 4 | 5 |  |  |
| 14. Wake up tired | 0 | 1 | 2 | 3 | 4 | 5 |  |  |
| 15. Fatigue | 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. Frustrated/restless/irritable | 0 | 1 | 2 | 3 | 4 | 5 |  |  |
| 19. Sad | 0 | 1 | 2 | 3 | 4 | 5 |  |  |
| 20. Embarrassed | 0 | 1 | 2 | 3 | 4 | 5 |  |  |
| 21. Sense of taste/smell | 0 | 1 | 2 | 3 | 4 | 5 |  |  |
| 22. Blockage/congestion of nose | 0 | 1 | 2 | 3 | 4 | 5 |  |  |

|  |  |
| --- | --- |
| **General**How frequently do you have sinus and nasal symptoms? This is the first episode. 3 times/year 4-6 times per year Monthly Weekly Daily ConstantlyDo your symptoms improve between episodes? Yes, they completely improve No, they never improve Sometimes, they improve They improve partiallyHow often do your baseline symptoms get worse? Never (The symptoms are always the same.) 1-3 times/year 4-6 times per year More than 6 times per yearWhich best describes your sense of smell? No problem with sense of smell Diminished sense of smell Loss of smell Detect bad odorHave you ever had a sinus CT or MRI scan? Yes No*If yes, please provide details (including dates) below.*Have you ever had a sinus or nasal surgery? Yes No*If yes, please provide details (including dates) below. Details* | **Page 4 of 7****DO NOT SCAN.****Allergy Page**Do you have any of these allergy symptoms? Sneezing fits Itchy ears Itchy eyes Itchy nose Runny nose Itchy throat Runny/watery eyes Scratchy roof of your mouthWhen are your allergy symptoms most apparent? Spring Summer Fall Winter Continuously throughout the yearHave you ever been tested for allergy? Never I have had skin testing for allergy. I have had blood testing for allergy.Have you received allergy shots? Never Yes, and they helped a great deal. Yes, and they helped somewhat. Yes, and they did nothing.**Asthma**Do you have asthma? Yes NoIf yes, what do you take for your asthma? Asthma inhalers Nebulizer treatments Oral steroids Theophylline Other**Trauma**Have you ever broken your nose? Yes NoHave you ever sustained other facial and/or head injuries? Yes No |

## Previous Treatments

Which antibiotics have you received over the past year?

 Amox and/or PCN

 Amox/clav (Augmentin)

 Azithromycin (Zithromax, Z-pak)

 Cefadroxil (Duricef)

 Cefdinir (Omnicef)

 Cefpodoxime (Vantin)

 Cefprozil (Cefzil)

 Cefuroxime (Ceftin)

 Cephalexin (Keflex)

 Ciprofloxacin (Cipro)

 Clarithromycin (Biaxin)

 Erythromycin

 Levofloxacin (Levaquin)

 Loracarbef (Lorabid)

 Moxifloxacin (Avelox)

 SMP/TMX (Bactrim, Sulfa)

 IV antibiotics

 Others

 Unknown

 None

Which antihistamines have you received over the past year?

 Cetirizine (Zyrtec)

 Cetirizine/decongestant (Zyrtec-D)

 Desloratadine (Clarinex)

 Desloratadine/decongestant (Clarinex-D)

 Diphenhydramine (Benadryl)

 Fexofenadine (Allegra)

 Fexofenadine/decongestant (Allegra-D)

 Levocetirizine (Zyzal)

 Loratadine (Claritin)

 Loratadine/decongestant (Claritin-D)

 Others

 Unknown

 None

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**DO NOT SCAN.**

Which nasal sprays have you used over the past year?

 Beclomethasone (Qnasal, Beconase)

 Budesonide (Rhinocort)

 Ciclesonide (Omnaris)

 Flunisolide (Nasarel)

 Fluticasone furoate (Veramyst)

 Fluticasone propionate (Flonase)

 Mometasone (Nasonex)

 Triamcinolone (Nasacort)

 Oxymetazoline (Afrin)

 Azelastine (Astelin)

 Fluticasone/azelastine (Dymista)

 Olopatadine (Patanase)

 Ipratropium bromide (Atrovent)

 Others

 Unknown

 None

What other treatments have you used over the past year?

 Montelukast (Singulair)

 Zileuton (Zyflo)

 Antifungal treatments

 Guaifenesin OTC (Mucinex)

 Nasal saline sprays

 Nasal saline irrigations

 Oral decongestants

 Systemic steroids

 Topical antibiotic irrigations/treatments

 Others

 Unknown

 None

## Review of Systems

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**DO NOT SCAN.**

*The following is a list of common symptoms and health problems. Please review the list and indicate with a check mark the symptoms and health problems that you are experiencing.*

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Yes** | **No** | **Treated by another physician** |  |  | **Yes** | **No** | **Treated by another physician** |
| **General** |  |  |  | **Gastro-intestinal** |
| Nausea |  |  |  | Heartburn |  |  |  |
| Weight gain |  |  |  | Belly pain |  |  |  |
| Weight loss |  |  |  | Diarrhea |  |  |  |
| Fevers/chills |  |  |  | Constipation |  |  |  |
| **Ears, Nose & Throat** | Vomiting |  |  |  |
| Hoarseness |  |  |  | **Skin** |
| Hearing loss |  |  |  | Rashes |  |  |  |
| Draining ear |  |  |  | Ulcers |  |  |  |
| Vertigo |  |  |  | **Musculo-skeletal** |
| Loud snoring |  |  |  | Muscle pain |  |  |  |
| Daytime sleepiness |  |  |  | Muscle weakness |  |  |  |
| Mouth sores |  |  |  | **Endocrine** |
| Tooth problems |  |  |  | Cold intolerance |  |  |  |
| Painful/difficult swallowing |  |  |  | Heat intolerance |  |  |  |
| Ringing in the ears |  |  |  | Excessive thirst |  |  |  |
| **Eyes** | **Hematologic** |
| Double vision |  |  |  | Anemia |  |  |  |
| Blurry vision |  |  |  | Bleeding |  |  |  |
| **Cardiac** | Bruising |  |  |  |
| Chest pain |  |  |  | **Neurological** |
| Short of breath |  |  |  | Seizures |  |  |  |
| **Respiratory** | **Psychiatric** |
| Wheezing |  |  |  | Depression |  |  |  |
| Cough |  |  |  | Anxiety |  |  |  |

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**DO NOT SCAN.**

**Past History**

Do you have any of the following medical problems?

 Arthritis

 Asthma

 Bleeding disorder

 Cataracts

 Chronic fatigue syndrome

 Depression

 Diabetes

 Fibromyalgia

 Gastritis

 Glaucoma

 Hepatitis

 High blood pressure

 Heart disease

 Immunodeficiency

 Kidney disease

 Meningitis

 Migraine headache

 Mitral valve prolapse

 Peptic ulcer disease

 Seizures

 Thyroid disease

 Tuberculosis (TB)

Please list your previous surgical procedures.

Please list your previous hospitalizations.

Do you have any other medical problems not listed above?

 Yes

 No

*(If yes, please give details.)*

Please list your current medications.

Are you allergic to any medications?

 Yes

 No

*(If yes, please give details.)*

**Family History**

Do any of your family members have any of the following conditions?

*(Please specify the family member.)*

|  |  |
| --- | --- |
|  Allergy Asthma Bleeding disorder Cancer |  Cystic fibrosis Heart disease Immunodeficiency |

**Social History**

|  |  |
| --- | --- |
| What is your occupation? |  |
| Have you had any recent change in your home or work environment? Yes No | Details |
| Do you smoke? Yes No | Details |
| Do you drink alcoholic beverages? Yes No | Details |
| Have you ever used cocaine or other illicit substances? Yes No*.* | Details |