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NOSE & SINUS

Name: _____ Date _____

Please answer the questions carefully. CIRCLE THE ANSWER AND PRINT LEGIBLY

1. Why are you here to see the doctor? _____ Yes No

2. Do you have NASAL BLOCKAGE OR CONGESTION? _____ Yes No

How long has it been present? _____ days _____ weeks _____ months _____ years

Severity: Mild Moderate Severe
Duration: Continual Comes & Goes
Location: Right Side Left Side Both Sides

What makes it worse?

Location: Indoors Outdoors Air Conditioning In a heated room
Time of day: Morning Afternoon Evening Night
Season: Spring Summer Fall Winter Year round
Body Position: Standing Sitting Lying Down
Activity:
Medication:
Food:

3. Do you have NASAL DRAINAGE? _____ Yes No

How long has it been present? _____ days _____ weeks _____ months _____ years

Severity: Mild Moderate Severe
Duration: Continual Comes & Goes
Location: Right Side Left Side Both Sides From Nostrils Down back of throat (post nasal drip)
Description: Clear Watery Thick Yellow White Bloody
When is it worse: Season: Spring Summer Fall Winter Year round
Location: Indoors Outdoors Air Conditioning In a heated room
Activity:

4. Do you have PAIN OR HEADACHES in your nose or sinus area? _____ Yes No

How long has it been present? _____ days _____ weeks _____ months _____ years

Severity: Mild Moderate Severe
Characteristics: Sharp Dull Throbbing Fullness Pressure-Like Feeling
Duration: Continual Comes & Goes
Location: Nose Above Eyes Behind eyes In cheeks In teeth
Frequency of Attacks: _____ x a day _____ x a week _____ x a month
When is it worse:
Duration of Attacks: _____ minutes _____ hours _____ days
When are they worse?
Time of Day: Morning Afternoon Evening Night
Season: Spring Summer Fall Winter Year round
Location: Indoors Outdoors Air Conditioning In a heated room
Body Position: Standing Sitting Lying Down
Activity:

Associated symptoms: Tenderness to pressure Vision Changes Nausea or Vomiting Dizziness

Have you been treated for these by another physician? If so please elaborate: _____

5. Do you have or have you had?

Attacks of sneezing Hives Frequent or prolonged colds Nasal polyps
Itching nose Eczema Middle ear problems Food allergy
Itching of throat or palate Asthma Bronchitis Aspirin allergy
Itching, watering eyes

6. Have any blood related family members had allergies? _____ Yes No

7. Have you ever had ALLERGY TESTING OR TREATMENT? _____ Yes No

Where: _____

What were you found allergic to? _____

How were you treated?

Control of environment Antihistamines and /or decongestants
Nose spray Cortisone-like drugs
Allergy shots

How long were you treated? _____

8. Do you use NOSE DROPS OR SPRAYS? _____ Yes No

Type: _____ Frequency: _____ x a day _____ x a week
Duration: _____ days _____ month _____ years

9. Do you have an abnormality of your SENSE OF SMELL? _____ Yes No

10. Do you have NOSEBLEEDS? _____ Yes No

11. Have you ever had an INJURY, BLOW, OR BREAK OF YOUR NOSE? _____ Yes No

When? _____ Where? _____

12. Do you smoke? _____ Yes No

13. Have you ever had any of the following diseases? When? (circle & date)

Red measles Strokes Yellow Jaundice Bleeding disorder
German measles Diabetes Lung disease Thyroid disease
Chicken pox Cancer Meningitis Syphilis
Mumps Seizures Encephalitis Nerve or psychiatric illness
Asthma Pneumonia Malaria Ulcer or stomach disease
Scarlet fever Arthritis Tuberculosis
Rheumatic fever Polio Diphtheria
Heart Murmur Heart attack High blood pressure

14. Is there a history of prolonged bleeding problems in even distant relatives? If so, describe _____

15. Have you ever had surgery? If so, when and for what: _____

16. Any other hospitalizations? If so, when and for what: _____

17. Are you allergic to Penicillin? Yes No Any other medicines: _____

18. Are you presently taking any medicine? If so, what: _____

19. If the following are deceased, of what did they die?

Mother _____ Sister(s) _____

Father _____ Brother(s) _____