UT Physicians

UTHealth | McGovern Medical School
The University of Texas Health Science Center at Houston

# New Patient Questionnaire

## Texas Sinus Institute



| 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?**

Next page→

*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→

**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 | | O |
| 2. Sneezing | 0 | 1 | 2 | 3 | 4 | 5 | | O |
| 3. Runny nose | 0 | 1 | 2 | 3 | 4 | 5 | | O |
| 4. Cough | 0 | 1 | 2 | 3 | 4 | 5 | | O |
| 5. Post-nasal discharge (dripping at the back of your nose) | 0 | 1 | 2 | 3 | 4 | 5 | | O |
| 6. Thick nasal discharge | 0 | 1 | 2 | 3 | 4 | 5 | | O |
| 7. Ear fullness | 0 | 1 | 2 | 3 | 4 | 5 | | O |
| 8. Dizziness | 0 | 1 | 2 | 3 | 4 | 5 | | O |
| 9. Ear pain | 0 | 1 | 2 | 3 | 4 | 5 | | O |
| 10. Facial pain/pressure | 0 | 1 | 2 | 3 | 4 | 5 | | O |
| 11. Difficulty falling asleep | 0 | 1 | 2 | 3 | 4 | 5 | | O |
| 12. Wake up at night | 0 | 1 | 2 | 3 | 4 | 5 | | O |
| 13. Lack of a good night's sleep | 0 | 1 | 2 | 3 | 4 | 5 | | O |
| 14. Wake up tired | 0 | 1 | 2 | 3 | 4 | 5 | | O |
| 15. Fatigue | 0 | 1 | 2 | 3 | 4 | 5 | | O |
| 16. Reduced productivity | 0 | 1 | 2 | 3 | 4 | 5 | | O |
| 17. Reduced concentration | 0 | 1 | 2 | 3 | 4 | 5 | | O |
| 18. Frustrated/restless/irritable | 0 | 1 | 2 | 3 | 4 | 5 | | O |
| 19. Sad | 0 | 1 | 2 | 3 | 4 | 5 | | O |
| 20. Embarrassed | 0 | 1 | 2 | 3 | 4 | 5 | | O |
| 21. Sense of taste/smell | 0 | 1 | 2 | 3 | 4 | 5 | | O |
| 22. Blockage/congestion of nose | 0 | 1 | 2 | 3 | 4 | 5 | | O |

Next page→

**General**

How frequently do you have sinus and nasal symptoms?
O This is the first episode.
O 3 times/year
O 4-6 times per year
O Monthly
O Weekly
O Daily
O Constantly

Do your symptoms improve between episodes?
O Yes, they completely improve
O No, they never improve
O Sometimes, they improve
O They improve partially

How often do your baseline symptoms get worse?
O Never (The symptoms are always the same.)
O 1-3 times/year
O 4-6 times per year
O More than 6 times per year

Which best describes your sense of smell?
O No problem with sense of smell
O Diminished sense of smell
O Loss of smell
O Detect bad odor

Have you ever had a sinus CT or MRI scan?
O Yes
O No
*If yes, please provide details (including dates) below.*

Have you ever had a sinus or nasal surgery?
O Yes
O No
*If yes, please provide details (including dates) below.*

*Details*

**Allergy Page**

Do you have any of these allergy symptoms?
O Sneezing fits
O Itchy ears
O Itchy eyes
O Itchy nose
O Runny nose
O Itchy throat
O Runny/watery eyes
O Scratchy roof of your mouth

When are your allergy symptoms most apparent?
O Spring
O Summer
O Fall
O Winter
O Continuously throughout the year

Have you ever been tested for allergy?
O Never
O I have had skin testing for allergy.
O I have had blood testing for allergy.

Have you received allergy shots?
O Never
O Yes, and they helped a great deal.
O Yes, and they helped somewhat.
O Yes, and they did nothing.

**Asthma**

Do you have asthma?
O Yes
O No

If yes, what do you take for your asthma?
O Asthma inhalers
O Nebulizer treatments
O Oral steroids
O Theophylline
O Other

**Trauma**

Have you ever broken your nose?
O Yes
O No

Have you ever sustained other facial and/or head injuries?
O Yes
O No

Next page→

**Previous Treatments**

Which antibiotics have you received over the past year?

O Amox and/or PCN
O Amox/clav (Augmentin)
O Azithromycin (Zithromax, Z-pak)
O Cefadroxil (Duricef)
O Cefdinir (Omnicef)
O Cefpodoxime (Vantin)
O Cefprozil (Cefzil)
O Cefuroxime (Ceftin)
O Cephalexin (Keflex)
O Ciprofloxacin (Cipro)
O Clarithromycin (Biaxin)
O Erythromycin
O Levofloxacin (Levaquin)
O Loracarbef (Lorabid)
O Moxifloxacin (Avelox)
O SMP/TMX (Bactrim, Sulfa)
O IV antibiotics
O Others
O Unknown
O None

Which antihistamines have you received over the past year?

O Cetirizine (Zyrtec)
O Cetirizine/decongestant (Zyrtec-D)
O Desloratadine (Clarinex)
O Desloratadine/decongestant (Clarinex-D)
O Diphenhydramine (Benadryl)
O Fexofenadine (Allegra)
O Fexofenadine/decongestant (Allegra-D)
O Levocetirizine (Zyzal)
O Loratadine (Claritin)
O Loratadine/decongestant (Claritin-D)
O Others
O Unknown
O None

Which nasal sprays have you used over the past year?

O Beclomethasone (Qnasal, Beconase)
O Budesonide (Rhinocort)
O Ciclesonide (Omnaris)
O Flunisolide (Nasarel)
O Fluticasone furoate (Veramyst)
O Fluticasone propionate (Flonase)
O Mometasone (Nasonex)
O Triamcinolone (Nasacort)
O Oxymetazoline (Afrin)
O Azelastine (Astelin)
O Fluticasone/azelastine (Dymista)
O Olopatadine (Patanase)
O Ipratropium bromide (Atrovent)
O Others
O Unknown
O None

What other treatments have you used over the past year?

O Montelukast (Singulair)
O Zileuton (Zyflo)
O Antifungal treatments
O Guaifenesin OTC (Mucinex)
O Nasal saline sprays
O Nasal saline irrigations
O Oral decongestants
O Systemic steroids
O Topical antibiotic irrigations/treatments
O Others
O Unknown
O None

Next page→

**Review of Systems**

*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 |
|---|---|---|---|
| **General** | | | |
| Nausea | O | O | O |
| Weight gain | O | O | O |
| Weight loss | O | O | O |
| Fevers/chills | O | O | O |
| **Ears, Nose & Throat** | | | |
| Hoarseness | O | O | O |
| Hearing loss | O | O | O |
| Draining ear | O | O | O |
| Vertigo | O | O | O |
| Loud snoring | O | O | O |
| Daytime sleepiness | O | O | O |
| Mouth sores | O | O | O |
| Tooth problems | O | O | O |
| Painful/difficult swallowing | O | O | O |
| Ringing in the ears | O | O | O |
| **Eyes** | | | |
| Double vision | O | O | O |
| Blurry vision | O | O | O |
| **Cardiac** | | | |
| Chest pain | O | O | O |
| Short of breath | O | O | O |
| **Respiratory** | | | |
| Wheezing | O | O | O |
| Cough | O | O | O |

| | Yes | No | Treated by another physician |
|---|---|---|---|
| **Gastro-intestinal** | | | |
| Heartburn | O | O | O |
| Belly pain | O | O | O |
| Diarrhea | O | O | O |
| Constipation | O | O | O |
| Vomiting | O | O | O |
| **Skin** | | | |
| Rashes | O | O | O |
| Ulcers | O | O | O |
| **Musculo-skeletal** | | | |
| Muscle pain | O | O | O |
| Muscle weakness | O | O | O |
| **Endocrine** | | | |
| Cold intolerance | O | O | O |
| Heat intolerance | O | O | O |
| Excessive thirst | O | O | O |
| **Hematologic** | | | |
| Anemia | O | O | O |
| Bleeding | O | O | O |
| Bruising | O | O | O |
| **Neurological** | | | |
| Seizures | O | O | O |
| **Psychiatric** | | | |
| Depression | O | O | O |
| Anxiety | O | O | O |

Next page→

## Past History

Do you have any of the following medical problems?

- O Arthritis
- O Asthma
- O Bleeding disorder
- O Cataracts
- O Chronic fatigue syndrome
- O Depression
- O Diabetes
- O Fibromyalgia
- O Gastritis
- O Glaucoma
- O Hepatitis
- O High blood pressure
- O Heart disease
- O Immunodeficiency
- O Kidney disease
- O Meningitis
- O Migraine headache
- O Mitral valve prolapse
- O Peptic ulcer disease
- O Seizures
- O Thyroid disease
- O Tuberculosis (TB)

Please list your previous surgical procedures.

Please list your previous hospitalizations.

Do you have any other medical problems not listed above?

- O Yes
- O No

*(If yes, please give details.)*

Please list your current medications.

Are you allergic to any medications?

- O Yes
- O 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.)*

- O Allergy
- O Asthma
- O Bleeding disorder
- O Cancer
- O Cystic fibrosis
- O Heart disease
- O Immunodeficiency

## Social History

What is your occupation?

Have you had any recent change in your home or work environment? Details

- O Yes
- O No

Do you smoke? Details

- O Yes
- O No

Do you drink alcoholic beverages? Details

- O Yes
- O No

Have you ever used cocaine or other illicit substances? Details

- O Yes
- O No.