

Name	MRN	DOB	Date
Telephone H	W	M	
Pharmacy Name	Telephone		
How did you hear about us? <input type="checkbox"/> Sent by another physician (If so, please give name below.) <input type="checkbox"/> Sent by a friend <input type="checkbox"/> Internet search <input type="checkbox"/> UT and/or TSI reputation <input type="checkbox"/> Other ( <i>Specify</i> )			
Physician #1 ( <input type="checkbox"/> sent by this physician)			
Name	Fax	Telephone	
Address	City, State	Zip	
Physician #2 ( <input type="checkbox"/> 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?

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## Nasal Symptom Inventory

The following rating scale will be used to complete the questions:

Scale	Severity Definition
0 <b>None</b>	Absent-NO symptom evident
1 <b>Mild</b>	Symptom clearly PRESENT but minimal awareness; easily tolerated
2 <b>Moderate</b>	Definite awareness of symptom that is bothersome, but tolerable
3 <b>Severe</b>	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
<b>Facial or sinus pressure</b> (pressure or fullness in the area behind the eyes, cheeks, forehead, or sinuses)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Facial or sinus pain</b> (pain in the area around the eyes, cheeks, forehead)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Headache</b> (dull to intense, throbbing pain in head)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Nasal congestion</b> (stopped up or stuffy nose)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Nasal obstruction</b> (inability to move air through the nose)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Post-nasal drip</b> (sinus drainage in the back of the throat)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Clear nasal discharge</b> (nasal mucus that is clear)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Discolored nasal discharge</b> (nasal mucus that is green, yellow, and/or brown)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Itchy nose/eyes/throat</b> (sensation of itchiness in the nose, eyes and/or throat)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Nose bleeds</b> (bleeding, not bloody mucus, from the nose)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Tiredness</b> (feeling worn out or drained due to chronic sinusitis)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Wheezing</b> (whistling sound from breathing, associated with chest tightness)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Cough</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Sense of smell</b> (reduced sense of smell or detection of bad odor)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

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**Other Treatments**

Have you seen another physician since your last visit?

- Yes
- No

If Yes, please provide details.

**Medications**

Please list your current medications.


Please list any other medications that you have taken since your last visit, but are not longer using.


Are you allergic to any medications?

- Yes
- No

*(If yes, please give details.)*

*Details*

**Comments**