THE CENTERS FOR ADVANCED ENT CARE

Siegel, Bosworth and Sorensen Division

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Patient Name: _____ Date:_____ DOB: _____

Sinusitis Questionnaire

1. How many antibiotic-treated episodes of sinusitis do you get per year?_____
2. What are your typical sinusitis symptoms? _____
3. How has your sinusitis been treated in the past? _____
4. Have you had sinus surgery?_____
   If so, when and by whom? _____
5. Do you have a history of allergies? _____
   Seasonal or year round? _____
6. Have you received allergy testing? _____
   If so, when? _____
7. What were your allergen sensitivities? _____
8. Are you currently followed by an allergist? _____
   If so, who is it? _____
9. Have you received or are you currently receiving allergy immunotherapy? _____
   If so, for how long? _____
10. Have you obtained a sinus CT scan in the past? _____
    If so, where was it performed and when? _____

PLEASE BRING A COPY OF ALL OF THE SINUS SCAN CD'S WITH YOU TO YOUR APPOINTMENT

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