



Does your asthma flare up in association with:

Discolored nasal drainage/discharge?  No  Yes  Not sure

Nasal sinus infection?  No  Yes  Not sure

Exercise or temperature change?  No  Yes  Not sure

How many asthma attacks have you had **during the past year?**

**0 1 2 3 4 5 6 More than 6**

How many emergency visits (to the hospital or doctor's office) did you have for your asthma **during the past year?**

**0 1 2 3 4 More than 4**

How many times were you hospitalized overnight for your asthma **during the past year?**

**0 1 2 3 4 More than 4**

How many times did you have a breathing tube inserted to help you breathe for your asthma (intubated) **during the past year?**

**0 1 2 3 4 More than 4**

Did your symptoms of asthma first appear before your sinus/nasal complaints?

No  Yes  They appeared near the same time

Have you ever had spirometry (breathing tests) to assess your asthma?

No  Yes

**If you have had any prior breathing tests, please obtain a copy of these results for our records.**

Which medications have you used in the past for asthma?

Atrovent  Theophylline/Theodur/Uniphyl

Intal/Tilade  Oxygen therapy

Proventil/Alupent/Ventolin/Metaprel  Oral steroids/Medrol/Prednisone

Beclovent/Aerobid/Vanceril

Other (please specify): \_\_\_\_\_

How often have you used asthma inhalers **during the past year?**

Please circle one. **Daily Weekly Monthly Rarely Never**

How many times did you use theophylline (Theodur/Slobid) **during the past year?**

**0 1 2 3 4 More than 4**

How many courses of oral steroids (Prednisone/Medrol) have you taken for your asthma **during the past year?**

**0 1 2 3 4 More than 4 Daily/Every other day**

**PAST MEDICAL HISTORY:**

Do you **HAVE** or **HAVE YOU BEEN TREATED** for any of the following?

(check all that apply)

Arthritis  Hepatitis  High blood pressure

Glaucoma  Asthma  Heart disease

Bleeding disorder  Peptic ulcer disease  Gastritis

Tuberculosis (TB)  Depression  Immunodeficiency

Diabetes  Mitral valve prolapse  Kidney disease

Thyroid disease  Seizures  Meningitis

Cataracts

Other (please specify): \_\_\_\_\_

Do you take **ASPIRIN** or any other **anti-inflammatory medication** on a regular basis?

No  Yes

**HOSPITALIZATIONS:**  None

Please list: Date Reason Hospital

\_\_\_\_\_

\_\_\_\_\_

**PREVIOUS SINUS OR NASAL SURGERIES:**  None

Please list: Date Reason Hospital

\_\_\_\_\_

\_\_\_\_\_

**\*\* Please obtain a copy of your previous operative report(s) from your surgeon(s) to bring to your appointment.**

**OTHER SURGERIES:**  None

Please list: Date Reason Hospital

\_\_\_\_\_

\_\_\_\_\_

**Trauma/broken bones?**  No  Yes (please describe):

\_\_\_\_\_

**Transfusion of blood products:** Please list:

\_\_\_\_\_

**List CURRENT MEDICATIONS (list all meds including ASPIRIN-containing products and all nasal sprays):**

**NAME DOSE FREQUENCY**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Do you have DRUG ALLERGIES?**  No  Yes

**LIST DRUG ALLERGIES:**

**DRUG REACTION**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**REVIEW OF SYSTEMS:**

The following is a list of health care problems/symptoms. Please mark only one answer 0-4 below to indicate the severity of the problem. After you mark 0-4, you should circle the \* if you are being treated by another doctor for a particular problem.

**0** This is not a problem

**1** This is a symptom but does not affect my quality of life

**2** This is a symptom and does affect my quality of life

**3** This is a symptom and worsens my quality of life

**4** I am not sure if this is a symptom

\* I am currently being treated by another doctor for this problem

**General:**

Nausea 0 1 2 3 4 \*

Recent weight loss 0 1 2 3 4 \*

Recent weight gain 0 1 2 3 4 \*

Fever 0 1 2 3 4 \*

Chills 0 1 2 3 4 \*

Night sweats 0 1 2 3 4 \*

Fatigue 0 1 2 3 4 \*

**Cardiopulmonary:**

Heart murmur 0 1 2 3 4 \*

Palpitations 0 1 2 3 4 \*

Chest pain 0 1 2 3 4 \*

Shortness of breath 0 1 2 3 4 \*

Wheezing 0 1 2 3 4 \*

Chest tightness 0 1 2 3 4 \*

**Gastrointestinal:**

Indigestion/heartburn 0 1 2 3 4 \*

Vomiting 0 1 2 3 4 \*

Change in stool 0 1 2 3 4 \*

Diarrhea 0 1 2 3 4 \*

Constipation 0 1 2 3 4 \*

Abdominal pain 0 1 2 3 4 \*

**Ears:**

Ringing 0 1 2 3 4 \*

Dizziness 0 1 2 3 4 \*

Vertigo 0 1 2 3 4 \*

Pain 0 1 2 3 4 \*

Drainage 0 1 2 3 4 \*

Hearing loss 0 1 2 3 4 \*

**Eyes:**

Recent change in vision 0 1 2 3 4 \*

Double vision 0 1 2 3 4 \*

**Mouth/Throat:**

Dryness 0 1 2 3 4 \*

Sores/ulcers 0 1 2 3 4 \*

Difficulty swallowing 0 1 2 3 4 \*

Pain on swallowing 0 1 2 3 4 \*

Hoarseness 0 1 2 3 4 \*

Drooling 0 1 2 3 4 \*

Choking on solids or liquids 0 1 2 3 4 \*

Lumps in your neck 0 1 2 3 4 \*

**Endocrine:**

Heat/cold intolerance 0 1 2 3 4 \*

Excessive thirst 0 1 2 3 4 \*

**Genito-urinary:**

Burning upon urination 0 1 2 3 4 \*

Frequency of urination 0 1 2 3 4 \*

Change in color of urine 0 1 2 3 4 \*

**Nervous system:**

Numbness 0 1 2 3 4 \*

Tingling 0 1 2 3 4 \*

Fainting 0 1 2 3 4 \*

Weakness 0 1 2 3 4 \*

Tremor 0 1 2 3 4 \*

**Psychological:**

Schizophrenia 0 1 2 3 4 \*

Depression 0 1 2 3 4 \*

**Disturbance of sleep:**

Loud snoring 0 1 2 3 4 \*

Excessive daytime sleepiness 0 1 2 3 4 \*

Difficulty falling asleep 0 1 2 3 4 \*

Difficulty staying asleep 0 1 2 3 4 \*

Stop breathing during sleep 0 1 2 3 4 \*

Wake up not feeling rested 0 1 2 3 4 \*

**FAMILY HISTORY:**

Please check all that apply to **your family members.**

Allergy  Cystic fibrosis  Sinus disease

Asthma  Immunodeficiency  High blood pressure

Bleeding disorder  Heart disease

Cancer If yes, please list type of cancer and relationship of family member with cancer: \_\_\_\_\_

Other disease ( please specify): \_\_\_\_\_

**SOCIAL HISTORY:**

Please state your current occupation: \_\_\_\_\_

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

No  Yes

If yes, please describe: \_\_\_\_\_

Do you **smoke** or have you **ever smoked** tobacco on a regular basis?  No  Yes

If yes, how many packs/cigars per day do/did you smoke? \_\_\_\_\_ Packs per day

How many years have/did you smoke(d)? \_\_\_\_\_ years

If you have stopped smoking, how long ago did you stop?

\_\_\_\_\_ Weeks \_\_\_\_\_ Months \_\_\_\_\_ Years (**circle one**)

Do you drink **alcohol**?  No  Yes

If yes, how much per day or week will you typically drink? \_\_\_\_\_ Per day **OR** \_\_\_\_\_ Per week

Did/Do you ever use **cocaine**?  No  Yes

Have you ever abused any **addictive substances**?  No  Yes

If yes, what drug(s) were used? \_\_\_\_\_

When did you last use this/these drug(s)? \_\_\_\_\_

**SYMPTOM INDEX SURVEY:**

Please rate the following individual items based on your AVERAGE symptoms over the previous 12 WEEKS. Symptoms that are not present or have been present for less than 12 weeks should be scored as 0. Please circle the appropriate number.

**0 = Absent 1 = Very Mild 2 = Mild 3 = Moderate 4 = Severe 5 = Very Severe**

Facial pain/pressure 0 1 2 3 4 5 Fevers 0 1 2 3 4 5

Facial Congestion/fullness 0 1 2 3 4 5 Halitosis (bad breath) 0 1 2 3 4 5

Nasal obstruction/blockage 0 1 2 3 4 5 Fatigue (tiredness) 0 1 2 3 4 5

Discolored or pus nasal discharge Dental pain 0 1 2 3 4 5

or post nasal drip 0 1 2 3 4 5 Cough 0 1 2 3 4 5

Decreased sense of smell 0 1 2 3 4 5 Ear pain/pressure/fullness 0 1 2 3 4 5

Headache 0 1 2 3 4 5

**Please estimate your medication use as indicated below based on your care for the last 12 months.**

Nasal Steroid Sprays (Vancenase, Beconase, Nasonex, Nasacort, Flonase, etc)

I currently use these medications  No  Yes

I used these medications for a total of \_\_\_\_\_ weeks in the last 12 months.

Anti-histamines (Allegra, Claritin, Zyrtec, etc)

I currently use these medications  No  Yes

I used these medications for a total of \_\_\_\_\_ weeks in the last 12 months.

Antibiotics

Number of courses in last 12 months. \_\_\_\_\_ courses

I spent a total of \_\_\_\_\_ weeks on antibiotics in the last 12 months.