Aspire ALLERGY & SINUS

SYMPTOM QUESTIONNAIRE

The following questionnaire is used to help your provider gain valuable information about the symptoms you're currently experiencing. Answer the questions rating the symptoms you've experienced over the past two weeks. **For patients under the age of 14, only rate the symptoms that apply to you.**

Patient Name: ______________________________

Patient Phone: ______________________________

Date: ______________________________

Things to consider:

- How severe is the problem when you experience it and how often does it occur? Circle the number that corresponds with how you feel.
- Identify the most significant areas affecting your health at this time in the last column (up to five).

	No problem	Very mild problem	Mild or slight problem	Moderate problem	Severe problem	Problem as bad as it can be	Total Score	Up to five most important items
1. Need to blow nose	0	1	2	3	4	5		☐
2. Sneezing	0	1	2	3	4	5		☐
3. Runny nose	0	1	2	3	4	5		☐
4. Cough	0	1	2	3	4	5		☐
5. Post-nasal discharge	0	1	2	3	4	5		☐
6. Thick nasal discharge	0	1	2	3	4	5		☐
7. Ear fullness	0	1	2	3	4	5		☐
8. Dizziness	0	1	2	3	4	5		☐
9. Ear pain	0	1	2	3	4	5		☐
10. Facial pain / pressure	0	1	2	3	4	5		☐
11. Difficulty falling asleep	0	1	2	3	4	5		☐
12. Waking up at night	0	1	2	3	4	5		☐
13. Lack of sleep	0	1	2	3	4	5		☐
14. Wake up tired	0	1	2	3	4	5		☐
15. Fatigue	0	1	2	3	4	5		☐
16. Reduced productivity	0	1	2	3	4	5		☐
17. Reduced concentration	0	1	2	3	4	5		☐
18. Frustrated / restless / irritable	0	1	2	3	4	5		☐
19. Sad	0	1	2	3	4	5		☐
20. Embarrassed	0	1	2	3	4	5		☐
TOTAL								

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Sinus headaches / facial pressure? ____________

Constant Congestion? ____________

Frequent sinus infections / colds? ____________

Score greater than 20? ____________

Has the patient had sinus surgery? ____________

Refer for sinus consult? Y / N