STANFORD HOSPITAL and CLINICS
STANFORD, CALIFORNIA 94305

CLINICS • ENT • SINUS
NEW PATIENT QUESTIONNAIRE

INSTRUCTIONS: Please answer all of the questions to the best of your ability *before* you come to your appointment. All responses will be kept strictly confidential.

1. What is the reason for your scheduled visit?

   ____

   What system or problem is bothering you the most?

   ____

2. **Are you having pain related to this visit?** No Yes

   a) Location of pain: ______________________________
   b) Describe the pain: ______________________________
   c) What makes it better? ______________________________
   d) What make it worse? ______________________________
   e) How long does the pain last? ______________________________

3. **Please rate the following symptoms on a severity scale of 0 (absent) to 4 (severe):**

Symptom					
Recurrent sinus infections	0	1	2	3	4
Facial pressure/pain	0	1	2	3	4
Nasal congestion	0	1	2	3	4
Runny nose/post-nasal drip	0	1	2	3	4
Discolored nasal discharge	0	1	2	3	4
Altered sense of smell	0	1	2	3	4

4. **Do you have hay fever or other allergy symptoms?** Y N

   Have you ever been tested for allergies? Y N When?

   ____

   If yes, please list your allergies ______________________________

   Did you receive allergy shots? __________ If yes, how long?__________ Did they help? __________

5. **Please rate the effectiveness of any of the following treatments that you have received (1=worst, 4= best):**

Treatment					
Antibiotics	1	2	3	4	Never received
Antihistamines (Claritin, Allegra)	1	2	3	4	Never received
Decongestants (Sudafed)	1	2	3	4	Never received
Nasal steroid sprays (Nasacort, Flonase, etc.)	1	2	3	4	Never received
Oral steroids (Prednisone, Medrol)	1	2	3	4	Never received

6. **Do you have RECURRENT INFECTIONS?** Y N If so, please answer the following questions:

   a. To the best of your recollection, please list all the antibiotics you have taken for sinus infections, and circle the ones that have been most effective:

   ____

   ____

   b. The longest period of time that you have been on a single antibiotic is:

   2 weeks or less 2-4 weeks 4 - 8 weeks More than 8 weeks

7. **Do you have NASAL CONGESTION?** Y N If so, please answer the following question:

   Which side is more affected? Right Left Both equally

8. **Do you have FACIAL PAIN OR PRESSURE?** Y N If so, please answer the following questions:

   a. On which side is your discomfort more prominent? R L Both

   b. Where is your discomfort most severe? (Check all that apply)

   ______ At the inner angle of the eye
   ______ Around or behind the eye
   ______ In the temple
   ______ In the cheeks
   ______ In the back of the head
   ______ On the forehead or brow
   ______ Other (please describe): ______________________________

   c. Has another physician ever diagnosed you with migraines? Y N

   If so, how often do you get migraines? ____________________

   Can you distinguish your migraine headache from your sinus pain? Y N

9. **Do you have NASAL DISCHARGE or POST-NASAL DRIP?** Y N If so, please answer the following question: Please check all that best describe the typical appearance of your drainage:

   ____ clear ____ opaque white ____ thin ____ thick
   ____ yellow ____ blood-tinged ____ green ____ other

10. **PAST MEDICAL HISTORY**

    Do you have or have you been treated for any of the following? (check all that apply)

    ____ asthma ____ heart disease ____ high blood pressure ____ gastritis/ulcers
    ____ fibromyalgia ____ stroke ____ osteoporosis ____ low/high thyroid
    ____ liver disease ____ depression ____ immunodeficiency ____ kidney disease
    ____ diabetes ____ seizures ____ bleeding disorder ____ cataracts
    ____cancer (type________________) ____ hepatitis (type______) ____ glaucoma

Please list any other health problems not listed above:

____

____

11. **HOSPITALIZATIONS AND OPERATIONS**

Date Reason/Procedure Hospital

____

____

____

____

____

12. **CURRENT MEDICATIONS** (please include any vitamins or herbal medications)

Name Dose Frequency

____

____

____

____

____

____

____

13. **MEDICATION ALLERGIES**

List any medication allergies and the type of reaction that occurs:(If none known, ❑ check here

____

____

14. **FAMILY HISTORY:** Please check all that apply to your family members

____ Allergy ____ Sinus disease ____ Asthma

____ Cystic fibrosis ____ Immunodeficiency ____ Bleeding disorder

____ Cancer (Type and relationship of family members: ______________________)

____ Other (List _________________________________)

15. **SOCIAL HISTORY:**

a. Your occupation: ___________________________

b. Do you presently smoke? Y N If yes, # packs per day? ___/#___ years?

Did you ever smoke in the past? Y N If yes, # packs per day? ___/#___ years?

c. Do you drink alcohol? Y N If yes, # drinks per day? ________

d. Have you ever used any other addictive substances? Y N If yes, what drug? _______

16. **REVIEW OF SYSTEMS: Please circle any of the health problems that pertain to you.**

a. **Ears:**	Ringing Hearing loss	Dizziness No Symptoms	Drainage
b. **Mouth/Throat:**	Pain or difficulty swallowing No Symptoms	Hoarseness	Lumps in Neck
c. **Cardiopulmonary:**	Chest Pain Heart murmur	Palpitations Cough	Shortness of breath No Symptoms
d. **Genitourinary:**	Burning on urination	Frequency of urination	No Symptoms
e. **Gastrointestinal:**	Heartburn Abdominal pain	Vomiting No Symptoms	Diarrhea
f. **Psychological:**	Depression	No Symptoms	
g. **Sleep pattern:**	Snoring Stop breathing during sleep	Daytime sleepiness No Symptoms	
h. **Endocrine:**	Heat intolerance No Symptoms	Cold intolerance	Excessive thirst
i. **Eyes:**	Recent change in vision No Symptom	Impaired vision	Double vision
j. **Neurologic:**	Weakness	Numbness	No Symptoms
k. **Musculoskeletal:**	TMJ disorder	Arthritis	No Symptoms
l. **General:**	Nausea Weight gain	Fever Weight loss	Fatigue No Symptoms
m. **Skin:**	Skin Cancer	No Symptoms	
n. **Hematologic/Lymphatic:**		Swollen Lymph Nodes	
o. **Allergic/Immunologic:**	Hepatitis	Frequent Infections	Immune Disorders
p.			

Thank you for completing this questionnaire. If you have questions about any of the above items, please ask your physician at the time of your appointment.

Completed by: ____________________ ***Date:*** _________ ***Relationship to Patient*** __________

Staff use only:

Reviewed by: ____________________ ***Date*** _________

I have personally reviewed the history and review of system:

________________________________ ______________

Attending Physician ***Date***