FREEHOLD EAR NOSE & THROAT ASSOCIATES, P.A.
Otolaryngology | Face To Face: Plastic & Cosmetic Surgery

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ALLERGY / SINUS QUESTIONAIRE

PLEASE CHECK, CIRCLE OR FILL IN THE BLANKS WHERE APPLICABLE

1. How many sinus infections have you had over the past 12 months? Number _____ N/A _____

2. Of the above episodes, how many required medical treatment by your physician?
   Number _____ N/A _____

3. Have you ever experienced the following symptoms? Check all that apply.
   Nasal stuffiness _____
   Runny / Itchy nose _____
   Postnasal drip _____
   Sneezing _____
   Nosebleeds _____
   Facial pressure between/under eyes _____
   Headache _____
   Watery/Itchy eyes _____
   Sore/Scratchy throat _____
   Taste or smell changes _____

4. When do your symptoms usually occur?
   Winter _____ Spring _____ Summer _____ Fall _____

5. Have you ever had any allergy testing before? Yes ____ Approx: Date _____ No _____

6. If you have allergy or sinus symptoms, how are you treated?
   Not treated _____ Self-medicated _____ Allergy shots _____

7. Do you suffer from headaches or migraines unrelated to nose or sinus problems?
   Yes _____ No _____

8. List any medications you have been treated with related to allergies or sinuses.
   (Ex: Antibiotics, decongestants, antihistamines, nasal sprays, etc. Include over the counter meds)
   _____
   _____

9. Have you ever had any previous x-rays or CT scans of the sinuses?
   Yes _____ Approx Date: _____ No _____

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