HNA Allergy & Asthma

Nasal/Sinus Worksheet

Name:_____ DOB:_____ Date_____

Do you have nasal obstruction/blockage/congestion:

- □ Yes, which side is worse ❒ right ❒ left ❒ both
- □ No

Do you use nasal sprays?

- □ Never
- □ Currently name of spray_____
- □ In the past name of spray_____

How many sinus infections have you been treated for in the past year? _____

Have you has a recent CT or MRI of your head/sinuses?

- □ No
- □ Yes Date_____ Location _____

Please check all symptoms that apply

- □ Nasal drainage
- □ Decreased sense of smell
- □ Headache, location_____
- □ Postnasal drainage
- □ Facial ❒ pain ❒pressure ❒ fullness
- □ Sneezing
- □ Itchy eyes or nose
- □ Watery eyes or nose

Have you ever been tested for allergies? ❒ Yes, result:_____

❒ No

Have you ever had allergy shots (allergy immunotherapy)?

❒ Yes, for how long?_____ Date stopped_____

❒ No

For office use only

Diagnosis:

Today's treatment: **Aims of treatment:**

L-M score:

Reviewed by:_____Date Reviewed:_____

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Sino-Nasal Outcome Test (SNOT 22)

Please circle the number that best describes your symptoms over the past **2 weeks.**

Use this scale to describe how bad the problem when it occurs →	No Problem	Very mild problem	Mild or slight Problem	Moderate problem	Severe problem	Worst the problem can be
Need to blow nose	0	1	2	3	4	5
Sneezing	0	1	2	3	4	5
Runny Nose	0	1	2	3	4	5
Cough	0	1	2	3	4	5
Post-Nasal drainage	0	1	2	3	4	5
Thick nasal discharge	0	1	2	3	4	5
Ear fullness	0	1	2	3	4	5
Dizziness	0	1	2	3	4	5
Ear pain/pressure	0	1	2	3	4	5
Facial pain/pressure	0	1	2	3	4	5
Difficulty falling asleep	0	1	2	3	4	5
Waking up at night	0	1	2	3	4	5
Lack of a good night's sleep	0	1	2	3	4	5
Waking up tired	0	1	2	3	4	5
Fatigue during the day	0	1	2	3	4	5
Reduced productivity	0	1	2	3	4	5
Reduced concentration	0	1	2	3	4	5
Frustrated/restless/irritable	0	1	2	3	4	5
Sad	0	1	2	3	4	5
Embarrassed	0	1	2	3	4	5
Loss of smell/taste	0	1	2	3	4	5
Congestion/obstruction of nose	0	1	2	3	4	5

Reviewed by:_____Date Reviewed:_____