AFFILIATED EAR, NOSE & THROAT PHYSICIANS

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Name: _____ Date: _____

Date of birth: _____

How long have you had your symptoms? _____

What symptoms do you experience? (check all that apply)

☐ Nasal congestion
☐ Runny nose
☐ Fever
☐ Headache
☐ Change in smell/taste
☐ Sneezing
☐ Cough
☐ Pressure in ears
☐ Hoarseness
☐ Other: _____
☐ Postnasal drainage
☐ Sore throat
☐ Facial pain/pressure
☐ Snoring

What have you taken OVER THE COUNTER in the past for your symptoms? (check all that apply)

☐ Claritin/Loratadine
☐ Benadryl
☐ Xyzal/Levocetirizine
☐ Neti Pot
☐ Tylenol Cold and Sinus
☐ Allegra/Fexofenadine
☐ Afrin Nasal Spray
☐ Saline Nasal Spray
☐ Ayr
☐ Sudafed
☐ Zyrtec/Cetirizine
☐ Flonase
☐ Zicam Allergy Relief
☐ Advil Cold and Sinus
☐ Dayquil/Nyquil

What PRESCRIPTIONS have you taken in the past for your symptoms? (check all that apply)

☐ Dymista
☐ QNasal
☐ Levaquin
☐ Amoxicillin
☐ Medrol Dose Pack
☐ Cephalexin
☐ Ceftin
☐ Nasonex
☐ Astepro
☐ Cipro
☐ Zithromax Z-Pack
☐ Avelox
☐ Keflex
☐ Omnicef/Cefdinir
☐ Palanase
☐ Astelin
☐ Augmentin
☐ Prednisone
☐ Doxycycline
☐ Atrovent
☐ Other: _____

How many times were you treated with an antibiotic therapy in the past 12 months? _____

- Allergy Testing (if you have a copy, please bring to appointment)
  - Date of test: _____
  - Test Results: _____
  - Did you do allergy desensitization (allergy injections)? Yes/No
    - ✓ If yes, for how long? _____

- Sinus CT (if you have a copy of your images and report, please bring to appointment):
  - Date of test: _____
  - Test Results: _____