

AFFILIATED  EAR, NOSE & THROAT
PHYSICIANS

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Name: _____ Date: _____

How long have you had allergy/sinus symptoms? _____

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

- | | | |
|--|---|---|
| <input type="checkbox"/> Nasal congestion | <input type="checkbox"/> Sneezing | <input type="checkbox"/> Post nasal drainage |
| <input type="checkbox"/> Runny nose | <input type="checkbox"/> Cough | <input type="checkbox"/> Sore throat |
| <input type="checkbox"/> Fever | <input type="checkbox"/> Pressure in ears | <input type="checkbox"/> Facial pain/pressure |
| <input type="checkbox"/> Headache | <input type="checkbox"/> Hoarseness | <input type="checkbox"/> Snoring |
| <input type="checkbox"/> Change in smell/taste | <input type="checkbox"/> Other: _____ | |

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

- | | | |
|---|---|---|
| <input type="checkbox"/> Claritin/Loratadine | <input type="checkbox"/> Allegra/Fexofenadine | <input type="checkbox"/> Zyrtec/Cetirizine |
| <input type="checkbox"/> Benadryl | <input type="checkbox"/> Afrin Nasal Spray | <input type="checkbox"/> Flonase |
| <input type="checkbox"/> Xyzal/Levocetirizine | <input type="checkbox"/> Saline Nasal Spray | <input type="checkbox"/> Zicam Allergy Relief |
| <input type="checkbox"/> Neti Pot | <input type="checkbox"/> Ayr | <input type="checkbox"/> Advil Cold and Sinus |
| <input type="checkbox"/> Tylenol Cold and Sinus | <input type="checkbox"/> Sudafed | <input type="checkbox"/> DayQuil/Nyquil |

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

- | | | |
|---|---|---------------------------------------|
| <input type="checkbox"/> Dymista | <input type="checkbox"/> Nasonex | <input type="checkbox"/> Palanase |
| <input type="checkbox"/> QNasal | <input type="checkbox"/> Astepro | <input type="checkbox"/> Astelin |
| <input type="checkbox"/> Levaquin | <input type="checkbox"/> Cipro | <input type="checkbox"/> Augmentin |
| <input type="checkbox"/> Amoxicillin | <input type="checkbox"/> Zithromax Z-Pack | <input type="checkbox"/> Predinsone |
| <input type="checkbox"/> Medrol Dose Pack | <input type="checkbox"/> Avelox | <input type="checkbox"/> Doxycycline |
| <input type="checkbox"/> Cephalexin | <input type="checkbox"/> Keflex | <input type="checkbox"/> Atrovent |
| <input type="checkbox"/> Ceftin | <input type="checkbox"/> Omnicef/Cefdinir | <input type="checkbox"/> Other: _____ |

Antibiotic History

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

What pharmacy do you usually fill prescriptions at? _____

Testing/Surgery

Have you had any of the following tests or surgeries?

- 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: _____
 - Any surgery performed? Yes/No
If yes, what was performed? _____