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Name:	Date:	
Date of birth:		
How long have you had your sympt	toms?	
Wh	at symptoms do you experience? (check all t	hat apply)
□ Nasal congestion	Sneezing	Postnasal drainage
🗆 Runny nose	🗆 Cough	Sore throat
Fever	Pressure in ears	Facial pain/pressure
🗆 Headache	Hoarseness	Snoring
□ Change in smell/taste	Other:	
What have you taken OVER THE COUN	TER in the past for your symptoms? (check all that	at apply)
Claritin/Loratadine	□ Allegra/Fexofenadine	□ Zyrtec/Cetirizine
🗆 Benadryl	🗆 Afrin Nasal Spray	Flonase
□ Xyzal/Levocetirizine	Saline Nasal Spray	🗆 Zicam Allergy Relief
🗆 Neti Pot	🗆 Ayr	Advil Cold and Sinus
Tylenol Cold and Sinus	🗆 Sudafed	🗆 Dayquil/Nyquil
What PRESCRIPTIONS have you taken	in the past for your symptoms? (check all that ap	oly)
🗆 Dymista	□ Nasonex	Palanase
🗆 QNasal	□ Astepro	🗆 Astelin
🗆 Levaquin	🗆 Cipro	🗆 Augmentin
🗆 Amoxicillin	Zithromax Z-Pack	🗆 Prednisone
Medrol Dose Pack	□ Avelox	Doxycycline
🗆 Cephalexin	□ Keflex	□ Atrovent
Ceftin	Omnicef/Cefdinir	□ Other:
How many times were you treated	with an antibiotic therapy in the past 12 mo	nths?
 Allergy Testing (if you have 	a copy, please bring to appointment)	
Date of test:		
Test Results:		
 Did vou do allergy 	desensitization (allergy injections)? Yes/No	
	or how long?	
• Sinus CT (if you have a cop	y of your images and report, please bring to a	appointment):
Date of test:		
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