

ALLERGIC SINUSITIS DETAILED QUESTIONNAIRE

By James Braly, MD

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Name: _____ Date: _____

Age: _____ Sex: _____ Weight: _____ Height: _____

Address: _____

Phone #: _____ E-mail: _____

Current Medical Conditions: _____

Have you been suffering from any of the following symptoms or conditions? Please indicate the frequency and severity of each by checking the appropriate box.

0 = never 1 = occasionally 2 = frequent but not severe 3 = occasional, moderate to severe

Signs & Symptoms

COMPLETE BY CIRCLING 0, 1, 2, 3

1	Chronic or intermittent pain/pressure in the cheeks and upper teeth, below the eyes, behind the nose &/or upper nose?	0	1	2	3
2	Headache?	0	1	2	3
3	Nasal congestion?	0	1	2	3
4	Runny nose?	0	1	2	3
5	Post-nasal drip?	0	1	2	3
6	Sneezing?	0	1	2	3
7	Thick discharge from the nose?	0	1	2	3
8	Loss or decrease in the sense of smell?	0	1	2	3
9	Loss or decrease ability to taste certain foods?	0	1	2	3
10	Repeated throat clearing?	0	1	2	3
11	Deviated nasal septum?	0	1	2	3
12	Nasal polyps (abnormal growth protruding inside nose)?	0	1	2	3
13	Recent upper respiratory infection which has lasted more than 10 days?	0	1	2	3
14	Asthma, chronic bronchitis, chronic cough and	0	1	2	3
15	Airborne allergies, hay fever or rhinitis?	0	1	2	3
16	Recurring middle ear infections (otitis media)?	0	1	2	3
17	Low grade fever?	0	1	2	3
18	Facial swelling, swelling under eyes?	0	1	2	3
19	Sensitive to aspirin, ibuprofen or other aspirin substitutes?	0	1	2	3

20	Above symptoms respond well to antibiotic therapy?	0	1	2	3
21	Above symptoms respond poorly to antibiotic therapy? (indicates noninfectious, allergic condition)	0	1	2	3
22	Sleep loss, snoring, sleep apnea	0	1	2	3
23	Daytime fatigue, brain fatigue, unclear thinking?	0	1	2	3

TOTAL SCORE = _____