

LOS ANGELES SINUS INSTITUTE

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PLEASE PRINT

Patient Name: _____ **Date:** ____/____/____

If there was only one symptom we could help you with, which would you have us relieve? _____

How long have you had this symptom: _____

What are your other symptoms? _____

How long have you had these symptoms? _____

Are your symptoms better, worse, or the same as it has been in the past? _____

Have you had any **CT scans** of your sinuses? No Yes
If so, when? _____

Have you used any of these treatments? (check all that apply)
 Saline spray Nasal Steroid sprays Air purifier Afrin
 Antihistamines Antibiotics Other: _____

Do you have **NASAL CONGESTION or BLOCKAGE (STUFFINESS)**?
 No Yes Yes, this is my main complaint
If yes which side of your nose is most often affected? Right Left Both

Do you have a **POST-NASAL DRIP or RUNNY NOSE**?
 No Yes Yes, this is my main complaint
If yes, is the drainage discolored or clear? _____

Do you have a change in your sense of **SMELL or TASTE**?
 No Yes Yes, this is my main complaint

Do you have **FACIAL PAIN/PRESSURE or HEADACHE**?
 No Yes Yes, this is my main complaint
If yes, where is the pain most prominent? _____

Do you have **ENVIRONMENTAL ALLERGIES**? No Yes
If yes, have you ever been tested for allergy? No Yes
If tested, were you found to have allergy? No Yes