

**CT SINUS DISEASE QUESTIONNAIRE**

Date: \_\_\_\_\_

Patient's Name: \_\_\_\_\_

1. Why did you go see the Doctor? \_\_\_\_\_

2. Who referred you to him? \_\_\_\_\_

3. Do you have any of these symptoms?  
\_\_\_\_ headache (indicate which part of head)      \_\_\_\_ nasal discharge  
\_\_\_\_ post-nasal drip      \_\_\_\_ stuffed nose  
\_\_\_\_ bloody nose      \_\_\_\_ loss of sense of smell  
\_\_\_\_ Other \_\_\_\_\_

4. How long have you had these symptoms? \_\_\_\_\_

5. Did you ever have sinus disease in the past? \_\_\_\_\_

6. How was it treated at the time? \_\_\_\_\_

7. Did you ever have trauma to your face, nose or sinuses? \_\_\_\_\_

Details: \_\_\_\_\_

8. Did you ever have surgery on your nose or sinuses? \_\_\_\_\_

Details: \_\_\_\_\_

Are you on any medicines for sinus problems at this time? \_\_\_\_\_

9. Are you on any medicines for sinus problems at this time? \_\_\_\_\_

10. How long have you been taking these medicines? \_\_\_\_\_

11. What did your doctor think was causing your symptoms? \_\_\_\_\_

12. When will you see your doctor again? \_\_\_\_\_

13. Have you ever had X-Rays or a C.T. of your sinuses before today? \_\_\_\_\_

When, where and what were the findings? \_\_\_\_\_

Technician's Signature: \_\_\_\_\_