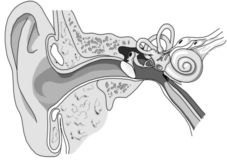
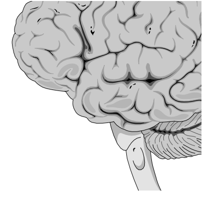


QUESTIONNAIRE

for patients with
SINUS OR ALLERGY



Chicago Dizziness and Hearing
645 N. Michigan, Suite 410
Chicago, Illinois, 60611
Voice: 312-274-0197, Fax: 312-376-8707
reception@dizzy-doc.com
Practice Portal: http://cdh.myupdox.com

Your Name: ______________________

Todays Date: ______________________

This is the first visit questionnaire for Dr. Mamikoglu. If you are scheduled to see Dr. Cherchi or Dr. Hain for the first time, please use one of the questionnaires at http://dizzy-doc.com/ If you have already filled this questionnaire out within the last 3 years don't do it again.

Once you are done, please return this questionnaire to us. We prefer fax, but there are many other options (see clinic website at http://dizzy-doc.com/). Getting the questionnaire to us a week ahead of time allows us to make your visit more efficient, and potentially avoid a second visit to the clinic for testing. While we will accept email attachments too, some email systems are not private, and if you do this, you are taking on a privacy risk.

Your care will be more efficient if you can provide us with pertinent test results, such as sinus CT scans, MRI scans of the head, and previous allergy test results.

If you have CD's of any scans of your head, please bring them with you so we can review them.

SINUS QUESTIONNAIRE

1. Chief Complaint

I am here because of (circle all that apply)

Sinus Problems

Allergy

Asthma

Note: if you are seeing the doctor for a different reason, ask the receptionist for the proper questionnaire. We have questionnaires for dizziness, headaches, tinnitus, and other health problems. Do not fill out multiple questionnaires – one is enough.

2. History of Present Illness

My symptoms started on: __________ or Age symptoms started _________

Mark the symptoms that you have now.

___Runny Nose ___Nasal Congestion ___Post Nasal Drip ___Sinusitis

___Headache ___Watery Eye ___Asthma ___Ear Infections

___Hives ___Urticaria ___Atopic Dermatitis ___Skin Rash

___Itching ___Dangerous reactions (anaphylaxis) ___Other _________

My symptoms are mainly present:

_____ All-year ___Spring ___Summer ___Fall ___Winter

If not all year round, my symptoms are present for:

___2-4 weeks ___1-3 months ___3-5 months __________

I already know I am allergic to:

___ nothing ___milk/milk products ___wheat ___corn

___sugar ___soy ___yeast ___peanuts __shellfish

___MSG ___ Sulfa drugs ___ Penicillin

History of severe reactions or anaphylaxis:

___never ___bee or wasp stings ___shellfish ___peanut

___other foods ___medications ___other___________________

I am interested in being tested for pollens, mold, and animal danders:
___yes ___no

SINUS QUESTIONNAIRE

Please circle appropriate number according to your symptoms
"0" means no problems, "10" means more problems.

1: Runny Nose

----

0 1 2 3 4 5 6 7 8 9 10

2: Nasal Congestion

----

0 1 2 3 4 5 6 7 8 9 10

3: Watery/Itchy Eyes

----

0 1 2 3 4 5 6 7 8 9 10

4: Cough

----

0 1 2 3 4 5 6 7 8 9 10

5: Post Nasal Drip

----

0 1 2 3 4 5 6 7 8 9 10

6: Headache/Sinus Pressure

----

0 1 2 3 4 5 6 7 8 9 10

7: Dizziness

----

0 1 2 3 4 5 6 7 8 9 10

8: Sneezing

----

0 1 2 3 4 5 6 7 8 9 10

9: Hives

----

0 1 2 3 4 5 6 7 8 9 10

SINUS QUESTIONNAIRE

Trigger substances that I think cause my symptoms

Allergic triggers	**YES**
House mites/dust	
Trees	
Grasses	
Weeds	
Mold	
Cats	
Dogs	
Other animals	
Foods	
Non-allergic triggers	
Tobacco smoke	
foods	
perfumes	
potpourri	
Weather changes	
Home cleaning supplies	
Gas/diesel fumes	
Auto exhaust	
Cold air	
Barometric changes	
Medications	
Heat or humidity	

Are there other triggers not listed above ?:

SINUS QUESTIONNAIRE

REVIEW OF SYSTEMS:

Constitutional

Weight Loss (15 LB or more)

Trouble sleeping?
Due to dizziness?
Due to depression?
Due to snoring?
Due to tinnitus?

CARDIOVASCULAR

Anemia

Fainting

Heart problems

High cholesterol

High blood pressure

Low blood pressure

Diabetes

Palpitations (abnormal or fast beating) of the heart

CANCER

What type and when?

ENDOCRINE

Low sugar (hypoglycemia)

Thyroid disorder

(Women only) are you
- pregnant?
- Recently pregnant ?
- Breast feeding ?
- Perimenopausal?
- Postmenopausal ?
  - With hot flashes ?

PSYCHOLOGICAL

Treatment by a psychiatrist or counselor

Depression

Unusual amounts of stress

PAIN

Arthritis

Pain in back of jaw (TMJ)

Migraine, Sinus or tension headaches

Low Back Pain

Neck Pain

IMMUNOLOGIC

Lupus

Rheumatoid arthritis

Immunodeficiency (e.g. low gamma globulin)

Other autoimmune disease

RESPIRATORY

Pneumonia

Sinusitis

Deviated Septum

GASTROINTESTINAL

Ulcer

Reflux/Hiatal Hernia

Irritable bowel

Chronic constipation

Chronic diarrhea

EYE PROBLEMS (other than glasses)

Cataract

Macular Degeneration

Double vision

NEUROLOGICAL PROBLEMS

B12 Deficiency

Memory loss

Meningitis

Multiple Sclerosis

Muscle, paralysis or weakness (where)

Seizures

RENAL/GENITOURINARY

Bladder Problem

Sexual function problem

Kidney problem

SINUS QUESTIONNAIRE

PAST MEDICAL HISTORY :

PREVIOUS SURGERY

- ☐ Breast cancer
- ☐ Ear
- ☐ Sinus
- ☐ Cataract
- ☐ Epidural Injection
- ☐ Stomach
- ☐ Carotid
- ☐ Hysterectomy
- ☐ Tonsil
- ☐ C-Section
- ☐ Prostate

If you have had sinus surgery, what exactly was done by who and when ?

Other Surgery _____

Injuries (circle)

to head (for example, facial fracture -- please list ALL)

to ears

Exposures (circle)

Loud noise (industrial)

Adverse environmental (such as "sick building")

Mold Inhalation

Toxins

PAST MEDICAL HISTORY: PREVIOUS STUDIES

Have you had any of these tests? (date if done and note result if known)

Previous allergy tests that were positive

Allergen	**YES**
House mites/dust	
Trees	
Grasses	
Weeds	
Mold	
Cats	
Dogs	
Other animals	
Foods	
Other	

These tests were done by: ___skin test RAST, ImmunoCap or other blood test

GENERAL MEDICAL TESTS

- ☐ Recent general medical checkup?
- ☐ Recent blood tests
  - Complete blood count
  - Cholesterol
  - Glucose/A1C
  - Thyroid tests (such as TSH)
  - P and C ANCA tests for Wegeners granulomatosis
  - Immunoglobulin testing for immunodeficiency

X-RAYS and MRI scans

- ☐ Chest X-ray
- ☐ Sinus: X-rays or CT scan

Other Important Tests the doctor should know about:

SINUS QUESTIONNAIRE

SOCIAL HISTORY

Smoking history: Do you smoke, or have you smoked in the past ?
(The federal government asks us to collect this information)

How much alcohol do you *drink per week*?

How much *salt* do you use on your food?

What sort of *work* do you do (or used to do)?

How often do you *fly on airplanes*?

Do spend much time where there is exposure to many airborne agents (such as a school or day-care) ?

Are you presently in litigation or planning litigation about symptoms related to this visit?

Are you disabled ?

Do you drive ?

FAMILY HISTORY

Are there any **family members** with (circle, list):

Allergy

Asthma

Migraine headache

Sinus Headache

Rhinitis (runny nose)

Other diseases that run in the family? (please list)

What is your ethnicity ? (The federal government asks us to collect this information)

MEDICATIONS

10a. What are your current medications, include hormones, allergy shots, birth control pills, (Name and amount/day)?

1.
2.
3.
4.
5.
6.
7.
8.
9.
10.

10b. What other medications have you taken in the last 5 years, for this problem ?

1.
2.
3.
4.
5.

10c. **Have you ever taken any of the following drugs? Mark the ones that you have taken.**

___oral antihistamines (e.g. allegra, Zyrtec) ___nasal antihistamines (e.g. astelin)

___nasal steroids (e.g. Flonase) ___nasal saline irrigation (e.g. Neti pot)

___nasal cromolyn sodium ___Atrovent (ipratropium nasal spray)

___decongestants (oral such as "Sudafed" or nasal spray such as "afrin")

___Singulair ___ Other inhalers for asthma including steroid inhalers

_____ systemic steroids (e.g. prednisone)

10.d If you have used decongestants, they provide:

___little or no relief ___moderate relief ___near total relief