MIDDLETOWN
MEDICAL IMAGING

SINUSES QUESTIONNARE

Name_____DOB_____AGE_____

How long have you had these symptoms? _____

Have you been on antibiotics? _____

If yes, how long? _____

Have you had previous sinus surgery? _____

Do you have a history of cancer of the face or sinuses? _____

Do you have a history of facial or nasal fracture? _____

Do you have a history of any of the following? Please check where appropriate.

Headaches _____

Excess Mucous Production _____

Visual Problems _____

Facial Pain _____

Post Nasal Drip _____

Others _____

_____

Patient's Signature _____