



# PATIENT HISTORY FORM

SCORE: (office use only).

**NAME:** \_\_\_\_\_ **DOB:** \_\_\_\_/\_\_\_\_/\_\_\_\_ **DATE:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**BRIEFLY DESCRIBE YOUR PRESENT SYMPTOMS:** \_\_\_\_\_

**OCCUPATION:** \_\_\_\_\_

**DRUG ALLERGIES:**  No  Yes If yes, please list: \_\_\_\_\_

**CURRENT MEDICATIONS:** Please list the name and dose of any medications that you are currently taking including prescription, non-prescription, AND vitamins or supplements.

- |          |           |
|----------|-----------|
| 1. _____ | 6. _____  |
| 2. _____ | 7. _____  |
| 3. _____ | 8. _____  |
| 4. _____ | 9. _____  |
| 5. _____ | 10. _____ |

**SEMAGLUTIDES/TIRZEPATIDE:**

Please indicate below if you are on any of the following due to anesthesia restrictions: Ozempic, Wegovy, Rybelsus, Mounjaro, Trulicity, Retatrutide, etc.

\_\_\_\_\_

**SURGICAL HISTORY (please include year):**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**PAST MEDICAL HISTORY:**

Do you now or have you ever had:

- |   |  |  |  |
|---|--|--|--|
| <input type="checkbox"/> Diabetes                   | <input type="checkbox"/> Leukemia            | <input type="checkbox"/> Cataracts               | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> High blood pressure        | <input type="checkbox"/> Psoriasis           | <input type="checkbox"/> Kidney disease          | <input type="checkbox"/> Tuberculosis    |
| <input type="checkbox"/> High cholesterol           | <input type="checkbox"/> Angina              | <input type="checkbox"/> Kidney stones           | <input type="checkbox"/> HIV/AIDS        |
| <input type="checkbox"/> Hypothyroidism             | <input type="checkbox"/> Heart murmur        | <input type="checkbox"/> Jaundice                | <input type="checkbox"/> Other _____     |
| <input type="checkbox"/> Goiter                     | <input type="checkbox"/> Pneumonia           | <input type="checkbox"/> Crohn's disease         | _____                                    |
| <input type="checkbox"/> Cancer (type and location) | <input type="checkbox"/> Pulmonary embolism  | <input type="checkbox"/> Colitis                 | _____                                    |
| _____   | <input type="checkbox"/> Asthma              | <input type="checkbox"/> Anemia                  | _____                                    |
| _____   | <input type="checkbox"/> Emphysema           | <input type="checkbox"/> Hepatitis               |  |
| _____   | <input type="checkbox"/> Stroke              | <input type="checkbox"/> Stomach or peptic ulcer |  |
|   | <input type="checkbox"/> Epilepsy (seizures) |  |  |

**HEART CONDITIONS:**

Please describe **ANY** of your **CURRENT OR PAST** heart conditions below:

\_\_\_\_\_

**SOCIAL HISTORY circle all that apply:**

**Smoking/Tobacco Use:**

Never Current Former

**Alcohol Consumption:**

Never Occasionally Frequently

**Illicit Drug Abuse:**

Yes No If yes, \_\_\_\_\_

**FAMILY MEDICAL HISTORY:**

Mother: \_\_\_\_\_

Father: \_\_\_\_\_

**FEMALES ONLY:**

First day of last menstrual cycle: \_\_\_\_\_



## Want to know if Balloon Sinuplasty IS RIGHT FOR YOU?

The following questionnaire is intended to help define your symptoms and provide valuable information and insights for your doctor. Answer the questions; rating to the best of your ability, the problems you experience on your WORST day of symptoms.

Patient Name: \_\_\_\_\_

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

### Sino-Nasal Outcome Test (SNOT-22)

<p>1. Consider how severe the problem is when you experience it and how frequently it happens, please rate each item below on how "bad" it is by circling the number that corresponds with how you feel.</p> <p>2. Please mark the most important items affecting your health (maximum of 5 items).</p>	No problem	Very mild problem	Mild or slight problem	Moderate problem	Severe problem	Problem is as bad as it can be		5 Most important items
1. Need to blow nose	0	1	2	3	4	5		0
2. Nasal obstruction (blockage)	0	1	2	3	4	5		0
3. Sneezing	0	1	2	3	4	5		0
4. Runny nose	0	1	2	3	4	5		0
5. Cough	0	1	2	3	4	5		0
6. Post-nasal drip	0	1	2	3	4	5		0
7. Thick nasal discharge	0	1	2	3	4	5		0
8. Ear fullness	0	1	2	3	4	5		0
9. Dizziness	0	1	2	3	4	5		0
10. Ear pain	0	1	2	3	4	5		0
11. Facial pain/pressure	0	1	2	3	4	5		0
12. Decreased sense of smell or taste	0	1	2	3	4	5		0
13. Difficulty falling asleep	0	1	2	3	4	5		0
14. Wake up at night	0	1	2	3	4	5		0
15. Lack of sleep	0	1	2	3	4	5		0
16. Wake up tired	0	1	2	3	4	5		0
17. Fatigue	0	1	2	3	4	5		0
18. Reduced productivity	0	1	2	3	4	5		0
19. Reduced concentration	0	1	2	3	4	5		0
20. Frustrated/ restless/ irritable	0	1	2	3	4	5		0
21. Sad	0	1	2	3	4	5		0
22. Embarrassed	0	1	2	3	4	5		0