Shasta ENT Specialists
Redding SINUS Center
George H. Domb M.D.

NEW PATIENT/SINUS INFORMATION

Patient Name:_____

Date:_____Birth Date:_____M/F:_____

Family Doctor:_____Referred By:_____

Reason for Your Visit:_____

Below you will find a list of symptoms, functional limitations, and emotional consequences of your rhinosinusitis. We would like to know more about these problems and how they impact your life. There is no "right" or "wrong" answers, and only you can provide us with this information. Please rate your problems as they have been RECENTLY. Do not hesitate to ask our doctors or staff members for help if necessary. Please refer to the following instructions and scales, circle the number that most accurately describes your experience.

Magnitude Scale

Considering how severe the problem is, when you get it and how frequently it happens, Please rate each item below on how "bad" it is using the following scale.

0 = Not present/No problem
1 = Very mild problem
2 = Mild to slight problem
3 = Moderate problem
4= Severe problem
5 = Problem is as "bad as it can be"

Importance Scale

For each item that has a magnitude of 1,2,3,4, or 5, please rate how important it is to you. Use the following scale.

1 = Not important
2 = Somewhat important
3 = Moderately important
4 = Extremely important

1. **Nasal Symptom**	**MAGNITUDE**	**IMPORTANCE**
Stuffy/blocked nose	0 1 2 3 4 5	1 2 3 4
Runny nose	0 1 2 3 4 5	1 2 3 4
Sneezing	0 1 2 3 4 5	1 2 3 4
Decreased sense of smell or taste	0 1 2 3 4 5	1 2 3 4
Postnasal discharge	0 1 2 3 4 5	1 2 3 4
Thick nasal discharge/debris	0 1 2 3 4 5	1 2 3 4
Bloody nose	0 1 2 3 4 5	1 2 3 4

2. **Eye Symptoms**		
Itchy, watery eyes	0 1 2 3 4 5	1 2 3 4
Swollen, sore eyes	0 1 2 3 4 5	1 2 3 4

3. **Sleep** **MAGNITUDE** **IMPORTANCE**

Difficulty getting to sleep……0 1 2 3 4 5……1 2 3 4
Wake up during the night……0 1 2 3 4 5……1 2 3 4
Lack of a good night's sleep……0 1 2 3 4 5……1 2 3 4
Wake up tired…… ……0 1 2 3 4 5……1 2 3 4

4. **General Symptoms**

Fatigue/worn out……0 1 2 3 4 5……1 2 3 4
Reduced productivity……0 1 2 3 4 5……1 2 3 4
Poor concentration……0 1 2 3 4 5……1 2 3 4
Headache……0 1 2 3 4 5……1 2 3 4
Facial pain/pressure……0 1 2 3 4 5……1 2 3 4
Cough……0 1 2 3 4 5……1 2 3 4
Short of breath……0 1 2 3 4 5……1 2 3 4

5. **Practical Problems**

Need to rub nose/eyes……0 1 2 3 4 5……1 2 3 4
Need to blow nose repeatedly……0 1 2 3 4 5……1 2 3 4
Bad Breath……0 1 2 3 4 5……1 2 3 4

6. **Tobacco Use:**

Y/N_____Since_____Quit?_____When?_____Chew_____

Cigarettes_____Packs/Day_____Pipe_____Cigar_____

7. **Alcohol Use:**

Never_____Daily_____Weekly_____Social_____Quit?_____When_____

8. **Allergies to Medication:**

_____

_____

9. **Medications you are now taking(including over –the – counter):**

_____

_____

10. **Medications you have taken in past(and way):**

_____

_____

11. **Do you take Blood Thinners** No_____ Yes_____

Plavix_____Aspirin_____Ibuprofen_____Persantine_____Coumadin_____

PLEASE CHECK IF YOU HAVE ANY OF THE FOLLOWING

Diabetes	_____	High Blood Pressure	_____
Hepatitis	_____	Asthma/Lung Problems	_____
Bleeding Tendency	_____	Thyroid Problems	_____
AIDS/HIV+	_____	Chest Pain/Stroke	_____
Ulcer	_____	Heart Attack/When?	_____
Prev. Ear Surgery	_____	Stroke	_____
Nose/Sinus Surgery	_____	Loud Noise Exposure	_____

12. **Please List Any Prior Surgeries:**

_____

_____

13. **Ladies:** Could You Be Pregnant?_____

Would you like Dr. Domb to know anything else about you?

_____

_____

_____

THANK YOU FOR FILLING OUT THIS FORM COMPLETELY

Shasta ENT Specialists
Redding SINUS Center
George H. Domb M.D.

NEW PATIENT MEDICAL INFORMATION SHEET

Patient Name:_____

Date:_____Birth Date:_____M/F:_____

Family Doctor:_____Referred By:_____

Reason for Your Visit:_____

PLEASE CHECK ANY CURRENT SYMPTOMS

1. Ears:
   - _____ Itchy
   - _____ Pain
   - _____ Drainage
   - _____ Hearing Loss
   - _____ Ringing
   - _____ Dizziness

2. Nose and Sinus:
   - _____ Runny Nose
   - _____ Post-Nasal Drip
   - _____ Stuffy or Congested
   - _____ Nosebleeds
   - _____ Problems with sense of smell
   - _____ Polyps

3. Mouth and Throat:
   - _____ Sore Throat
   - _____ Tonsillitis
   - _____ Mouth Breathing
   - _____ Problems Swallowing
   - _____ Hoarseness

4. Snoring:
   - _____ Yes _____No
   - _____ Daytime Sleepiness

5. Tobacco Use:

   Y/N_____Since_____Quit?_____When?_____Chew_____

Cigarettes_____Packs/Day_____Pipe_____Cigar_____

6. Alcohol Use:
   Never_____Daily_____Weekly_____Social_____Quit?_____When_____

7. Allergies to Medications:

   _____

   _____

8. Medications you are now taking, including over –the – counter:

   _____

   _____

9. Medications you have taken in past(and way):

   _____

   _____

10. Do you take Blood Thinners? No_____ Yes_____
    Plavix_____Aspirin_____Ibuprofen_____Persantine_____Coumadin_____

PLEASE CHECK IF YOU HAVE ANY OF THE FOLLOWING

Diabetes	_____	High Blood Pressure	_____
Hepatitis	_____	Asthma/Lung Problems	_____
Bleeding Tendency	_____	Thyroid Problems	_____
AIDS/HIV+	_____	Chest Pain/Stroke	_____
Ulcer	_____	Heart Attack/When?	_____
Prev. Ear Surgery	_____	Stroke	_____
Nose/Sinus Surgery	_____	Loud Noise Exposure	_____

11. Please List Any Prior Surgeries:

    _____

    _____

12. Ladies: Could You Be Pregnant? _____

Would you like Dr. Domb to know anything else about you?

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