

INTAKE FORM - NOSE/SINUS

Name: _____ DOB (dd/mm/yyyy): _____

What issues prompted your referral to Dr. Mabini? (please circle):

Nasal/sinus congestion

Nosebleeds

Recurrent sinus infections

Nasal polyps

Other: _____

Do you have, or have you had any of the following symptoms? (please check if yes):

☐ Recurrent throat infections (e.g. colds)

☐ Snoring

☐ Frequent sinus pain/pressure

☐ Sleep apnea

☐ Excessive mucous production/runny
nose

☐ Ear pain/pressure

☐ Ear infections

☐ Nasal polyps

☐ Headaches

☐ Trouble breathing through your nose

☐ Decreased sense of taste or smell

Have you had previous sinus surgery? _____

Do you have environmental/seasonal allergies? Have you ever had allergy testing?:

Do you use any nasal steroid sprays or nasal saline rinses (e.g. Neti pot)? How long have you used it consistently (i.e. on a daily basis)?:

Have you ever been treated with antibiotics for a sinus infection?:

Have you ever had trauma to your nose or face (e.g. broken nose)?:
