SINUSITIS & RHINITIS LOG

VETERAN INFORMATION AND BASELINE

Veteran Advocacy Group LLC | VA Accredited Claims Agent

Accreditation #60676 | POA Code KW9 | 272-257-1349 | claims@veteran-advocacy.com | www.veteran-advocacy-group.com

VETERAN INFORMATION

Veteran name _____

VA file number (last 4 only) _____

Log start date _____

Primary phone _____

Email _____

Representative / provider _____

CONDITION BASELINE

Diagnosis, if known _____

Treating provider _____

Known allergies / triggers _____

Date symptoms began _____

Typical frequency _____

Typical severity (0-10) _____

CURRENT TREATMENT

Medication / antibiotic	Dates / frequency	Benefit	Side effects

HOW TO USE THIS LOG

Record symptoms as soon as practical. Include frequency, severity, duration, treatment, and what the condition prevented or made difficult. Describe effects on employment, relationships, sleep, mobility, self-care, driving, and household activities. Record only events and limitations actually experienced. Keep related medical and employment records. Record prescribed antibiotic dates and provider-directed bed rest accurately; keep related visit and prescription records.

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SEVEN-DAY SYMPTOM AND FUNCTIONAL-IMPACT SUMMARY

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Veteran name	Week beginning	Week ending

DAILY SUMMARY

Date	Symptoms 0-10	Obstruction	Pain / headache	Discharge / crusting	Treatment	Daily impact

WEEKLY FUNCTIONAL IMPACT

Total episodes / symptom days	Severe symptom days	Care or treatment contacts

Work hours lost	Appointments / activities missed	Help needed from another person

Weekly notes, patterns, triggers, or changes:

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DETAILED SYMPTOM OR EPISODE RECORD

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Veteran name _____

Date _____

Condition / affected area _____

SYMPTOM OR EPISODE DETAILS

[ ] Congestion [ ] Facial pain / pressure [ ] Headache [ ] Purulent discharge [ ] Crusting

[ ] Sneezing / itching [ ] Reduced smell [ ] Antibiotic treatment

Episode start / end _____

Symptoms and severity _____

Side and degree of obstruction _____

Discharge / crusting description _____

Provider visit / antibiotic course _____

TREATMENT, RESPONSE & WITNESSES

Bed rest or missed activity _____

Work / sleep / daily impact _____

Medication / treatment used _____

Relief: none / partial / complete _____

Time until recovery _____

FUNCTIONAL IMPACT

[ ] Continued normally [ ] Reduced activity [ ] Stopped activity [ ] Needed rest

[ ] Needed assistance [ ] Missed work [ ] Left early [ ] Missed appointment

Work or activity time lost _____

Person who observed / assisted _____

Provider contacted _____

Describe exactly what the symptoms prevented, interrupted, or required help completing:

_____

_____

_____

_____