Nasal Symptom History:

Age of onset of these symptoms:	_____
Seasons when symptoms are worst *(circle all that apply)*	Spring / Summer / Fall / Winter/ Year Round
Seasons when symptoms are best *(circle all that apply)*	Spring / Summer / Fall / Winter
Duration of symptoms *(circle all that apply)*	Days / Weeks at a time / Constant
Triggers for symptoms *(circle all that apply)*	Cats / Dogs / Dust / Smoke / Strong Odors / Yardwork / Windy Days / Other: _____

Fill out the sections that address the symptoms you experience

YES	NO	Symptoms	YES	NO	Symptoms
□	□	Stuffy nose	□	□	Itchy / red / watery eyes
□	□	Runny nose	□	□	Frequent yellow / green nasal discharge
□	□	Frequent sneezing	□	□	Snoring
□	□	Drainage down your throat	□	□	Intermittent / chronic ear popping / plugging
□	□	Itchy nose	□	□	Loss of sense of smell
□	□	Sinus pressure/chronic or recurrent headaches	□	□	Ear infections If yes, how many in past year? _____

Patient Name:_____
DOB:_____
Today's Date:_____