Rocky Mountain ENT

700 West Kent - Missoula, MT 59801 - (406) 541-3277 (EARS) or 1 800-255-8698

SINUS INTAKE FORM

Date:

1. **Specifically, how are your symptoms related to your sinuses? How long have you experienced symptoms?**
   a. Nasal obstruction or congestion?

   b. Discolored nasal drainage?

   c. Facial pain or pressure?

   d. Decreased sense of smell and taste?

2. **Please list any medications you have taken for your sinuses.**

3. **If you have taken antibiotics, please list dosage and duration.**

4. **Do you have a history of allergy?**
   a. Have you taken medications for allergy? If yes, please list.

   b. Have you had allergy testing? If yes, where, when, and what were the results?

   c. Have you undergone desensitization therapy?

5. **Do you have a history of Aspirin sensitivity?**

6. **Do you have asthma?**

7. **Have you had any CT scan or MRI scans of your sinuses? If yes, where and when?**

8. **Have you had sinus or nasal surgery?**