



NORTH DOVER  
R A D I O L O G Y

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*SINUSES QUESTIONNAIRE*

Name \_\_\_\_\_ DOB \_\_\_\_\_ AGE \_\_\_\_\_

How long have you had these symptoms? \_\_\_\_\_

Have you been on antibiotics? \_\_\_\_\_

If yes, how long? \_\_\_\_\_

Have you had previous sinus surgery? \_\_\_\_\_

Do you have a history of cancer of the face or sinuses? \_\_\_\_\_

Do you have a history of facial or nasal fracture? \_\_\_\_\_

Do you have a history of any of the following? Please check where appropriate.

Headaches \_\_\_\_\_

Excess Mucous Production \_\_\_\_\_

Visual Problems \_\_\_\_\_

Facial Pain \_\_\_\_\_

Post Nasal Drip \_\_\_\_\_

Others \_\_\_\_\_

\_\_\_\_\_

Patient's Signature \_\_\_\_\_