

**Chihal ENT Associates, P.A.
Allergy and/or Sinus Patients**

Patient Name: _____ **Date:** _____

What are your primary allergy or sinus infection symptoms? _____

List medications you are currently taking for allergy or sinus treatment, include prescription and over the counter medications.

List medications (other than those listed above) you have tried in the past for allergy or sinus treatment. Include prescription and over the counter medications.

Number of sinus infections requiring treatment you have had in the last 12 months

Names (or if unknown, number of rounds) of antibiotics you have required in the last 12 months for sinus infections

Have you ever had a CT scan or other imaging of your sinuses? _____

Have you ever been on allergy shots? _____

When do you have the most allergy or sinus problems (circle all that apply)

Summer Fall Winter Spring All Year Round

List number and type of pets in your home _____

Does anyone in your home smoke? _____ Indoors / Outdoors