



Functional Nose Information Sheet

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

- 1: Do you feel discomfort or pressure in your cheek bones or forehead area where your sinuses are located? No Yes
- 2: Do you experience sinus headaches? No Yes
- 3: Do you experience sinus infections? No Yes
- 4: Are you a “mouth breather”? No Yes
- 5: Do you snore? No Yes
- 6: Have you had any trauma to your nose? No Yes
- 7: Do you wake up at night due to breathing problems? No Yes
- 8: Do you find yourself tired as a consequence of waking up due to breathing problems? No Yes
- 9: If yes, does this interfere with your daily function or job performance? No Yes
- 10: Do your breathing problems limit your participation in activities such as running, sports, or other forms of exercise? No Yes

11: Have you seen a medical doctor for treatment of this condition?

If yes, please give the following information:

Doctor's name: \_\_\_\_\_

Address: \_\_\_\_\_

Treatment dates \_\_\_\_\_

\*What treatment was advised?

12: Did you obtain relief from the treatment? No Yes

13: Do you have seasonal allergies? No Yes