



WOODBRIDGE

RADIOLOGY

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 _____