

PATIENT NAME _____ DATE _____

FUNCTIONAL NOSE INFORMATION SHEET

	YES	NO
Do you have any difficulty breathing through your nose?	<input type="checkbox"/>	<input type="checkbox"/>
Do you experience sinus headaches?	<input type="checkbox"/>	<input type="checkbox"/>
Are you a mouth breather?	<input type="checkbox"/>	<input type="checkbox"/>
Do you experience sore throats and dry chapped lips in the morning as a result of mouth breathing?	<input type="checkbox"/>	<input type="checkbox"/>
Do you snore?	<input type="checkbox"/>	<input type="checkbox"/>
Do you find that it is harder to breathe through your nose when lying down?	<input type="checkbox"/>	<input type="checkbox"/>
Do you find it necessary to prop yourself up on more than one pillow?	<input type="checkbox"/>	<input type="checkbox"/>
Do you use any of the following?		
Nasal irrigations or sprays?	<input type="checkbox"/>	<input type="checkbox"/>
Vaporizer?	<input type="checkbox"/>	<input type="checkbox"/>
Humidifier?	<input type="checkbox"/>	<input type="checkbox"/>
Do you take over-the-counter nose sprays and decongestants? If yes, please list them:	<input type="checkbox"/>	<input type="checkbox"/>

(continued)

YES NO

Do you wake up at night due to difficulty breathing through your nose?

Do your breathing problems limit your participation in activities such as running, sports, or other forms of exercise?

Do you find yourself tired during the day as a consequence of waking up at night due to breathing difficulty?

If yes, does this interfere with your daily function or job performance?

Have you seen a medical doctor for treatment of the breathing problem through your nose?

Doctor's name _____

Address _____

Treatment dates _____

What treatment was advised? _____

Did you benefit from the treatment?