Nose Complaints Medical Questionnaire Form

office@paulmontgomery.co.uk

Name: **D.O.B.**

Address: **Email:**

Mobile:

Date of completion of Questionnaire:

Your Nose Problems

Please describe:

Specific Nose Problems at Present (Please circle your response)

Nose Blockage YES/NO RIGHT NOSTRIL/LEFT NOSTRIL/BOTH NOSTRILS

Sinus Pains YES/NO RIGHT NOSTRIL/LEFT NOSTRIL/BOTH NOSTRILS

Nose Bleeds YES/NO RIGHT NOSTRIL/LEFT NOSTRIL/BOTH NOSTRILS

Catarrh/Phlegm YES/NO

Ability to Smell? NORMAL/REDUCED/NONE

Have you treated nose problems with more than 3 Months of continuous Steroid Nasal Sprays YES/NO

How helpful was it?

Previous Nose disease YES/NO
Please describe:

Other Medical Conditions – YES/NO
Please describe:

Your Medicines – YES/NO
Please describe:

Your Allergies – YES/NO
Please describe:

Any Family History of Diseases – YES/NO
Please describe: