PATIENT NAME ______________________________ DATE ____________

FUNCTIONAL NOSE INFORMATION SHEET

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

	YES	NO
If yes, does this interfere with your daily function or job performance?	☐	☐
Have you seen a medical doctor for treatment of the breathing problems through your nose?	☐	☐

Doctor's name ______________________________

Address ______________________________

Treatment dates ______________________________

What treatment was advised ______________________________

____

Did you benefit from the treatment?	☐	☐