Robert J. DeFatta, MD, PhD, FACS
Rima A. DeFatta, MD
Nicole S. Smith, AuD, CCC-A
Trista M. Williams, AuD, CCC-A

DeFatta ENT
FACIAL PLASTIC SURGERY

1490 Rivers Edge Trail
Altoona, WI 54720
P: 715-828-2ENT
F: 715-839-7796
www.DeFattaENT.com

ALLERGIC HISTORY

**** Please complete and bring on testing day*****

NAME: _____AGE: _____DATE: _____

Top 3 Symptoms in order of severity (#1 being the worst):

1) _____

2) _____

3) _____

List all medications to which you have had an allergy or sensitivity. Please specify the type of reaction to each medication. **INCLUDE** ALL OVER THE COUNTER MEDICATIONS AND MEDICATIONS THAT YOU TAKE AS NEEDED.

_____

_____

_____

List all foods to which you have been told you are allergic or have had adverse symptoms after eating. Also include the nature of the reactions/symptoms to those food.

_____

_____

ENVIRONMENT:
Please check everything that applies to your home. Answer to the best of your knowledge.

Age of house: ____years old
Does your home have mold or water damage? ____Yes ____No
If yes for mold, where? ____Basement ____Bathroom ____Windows ____Ceiling
Other_____
Flooring in your home: ____Carpet ____Linoleum ____Tile ____Hardwood/laminate
In your bedroom do you have? ____Stuffed toys ____Feather pillow/Down comforter
Do you have? ____Dehumidifier ____Humidifier
Do you have? ___Inside dogs ____Outside dogs ____Inside Cats ____Outside cats ___Birds
Do you have any other pets? _____
Do you live on a farm or do you often visit a farm? ____Yes ____No
Are you exposed to? ____ Horses ____Cows
Any allergy to animals? ____ Yes ____No
If yes, which animals? _____
Any allergy to smoke? _____Yes _____No
If yes, what kind of smoke? I.e. cigarette, campfire_____
Please tell us about any other questions or concerns

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Patient Name_____ DOB_____

Sino-Nasal Outcome Test Questionnaire

Considering how severe the problem is when you experience it & how frequently it happens, please rate each item below on how 'bad' it is by circling the number.	**No problem**	**Very mild problem**	**Mild or slight problem**	**Moderate problem**	**Severe problem**	**Problem as bad as it can be**	**Rate your top 3 symptoms, 1 being the worst**
1. Sneezing	0	1	2	3	4	5	
2. Need to blow nose	0	1	2	3	4	5	
3. Runny Nose	0	1	2	3	4	5	
4. Thick nasal discharge	0	1	2	3	4	5	
5. Post nasal drip	0	1	2	3	4	5	
6. Nasal blockage/congestion	0	1	2	3	4	5	
7. Headache	0	1	2	3	5	4	
8. Cough	0	1	2	3	4	5	
9. Ear fullness	0	1	2	3	4	5	
10. Ear pain/pressure	0	1	2	3	4	5	
11. Ringing/noise in ears	0	1	2	3	4	5	
12. Itchy ears	0	1	2	3	4	5	
13. Ear drainage	0	1	2	3	4	5	
14. Facial pain/pressure	0	1	2	3	4	5	
15. Dizziness	0	1	2	3	4	5	
16. Itchy Eyes	0	1	2	3	4	5	
17. Watery Eyes	0	1	2	3	4	5	
18. Swollen Eyes	0	1	2	3	4	5	
19. Difficulty falling asleep	0	1	2	3	4	5	
20. Waking up at night	0	1	2	3	4	5	
21. Waking up tired	0	1	2	3	4	5	
22. Fatigue during the day	0	1	2	3	4	5	
23. Reduced productivity	0	1	2	3	4	5	
24. Reduced concentration	0	1	2	3	4	5	
25. Frustrated/restless/ irritable	0	1	2	3	4	5	
26. Sad	0	1	2	3	4	5	
27. Embarrassed	0	1	2	3	4	5	
28. Decreased Sense of taste/smell	0	1	2	3	4	5	