**Acute Visit Questionnaire – Sinus Congestion**

**Chief Complaint:**

|  |  |
| --- | --- |
| Onset/Preceding event |  |
| Duration |  |
| What makes it better |  |
| What makes it worse |  |
| Severity |  |
| Allergies |  |
| Phlegm (Yes or No) |  |
| Fever (Yes or No) |  |
| Headache (Yes or No) |  |

**Additional reasons for my visit:**

**I am hoping to achieve the following goals from my visit:**

**My Past medical history:**

|  |  |
| --- | --- |
| Diagnosis | Duration |
|  |  |
|  |  |
|  |  |
|  |  |

**My Allergies:**

**My Medications:**

|  |  |
| --- | --- |
| Name | Dose |
|  |  |
|  |  |
|  |  |

**My Social History:**

|  |  |
| --- | --- |
| Occupation |  |
| Smoking |  |
| Drugs |  |
| Alcohol |  |