

HEAD AND SINUS CLINICAL INFORMATION SHEET

Name _____ Age _____ Today's Date _____

Sex _____ Weight _____ Referring Physician: _____

1. Why are you having this test? _____

2. Indicate symptoms *please write "YES" next to all that apply*:

a. _____ Headache: Acute: _____ Chronic: _____ Frequency: _____ Duration: _____

b. _____ Sinusitis

c. _____ Fever

d. _____ Nausea

e. _____ History of trauma

f. _____ Vomiting

g. _____ Dizziness

h. _____ Seizures

i. _____ Memory loss

j. _____ Hearing loss

k. _____ Facial Pain

l. _____ Numbness

m. _____ Tingling

n. _____ Double vision

o. _____ Blurred vision

p. _____ Speech difficulty

q. _____ Eye muscle weakness

r. _____ Prior surgery? If yes, what type, where: _____

3. Other information/complaints which you feel may be helpful: _____
