GEOFFREY R. KEYES, M.D.
NASAL HISTORY

Name: _____ Date: _____

(Please Circle)

1.) Have you ever had nasal surgery? No Yes

If yes, when?_____

2.) Have you ever injured your nose? No Yes

If yes, when?_____

3.) Was your injury treated? No Yes

If yes, how?_____

4.) Do you have trouble breathing through your nose? No Yes

If yes, which side? Left Right Both

5.) Do you have post-nasal drip? No Yes

6.) Do you have allergies or hay fever? No Yes

7.) Have you been told you have a deviated nasal septum? No Yes

8.) Have you ever been told you have nasal polyps? No Yes

9.) Have you ever had sinus trouble? No Yes

10.) Do you have bleeding from the nose? No Yes

11.) Do you have bleeding disorders? No Yes

12.) Do you bruise easily? No Yes

13.) What do you feel is the chief ***medical*** problem with your nose?

_____

_____

_____

PT#_____