PATIENT NAME	_DATE	
FUNCTIONAL NOSE INFORMATION SH	HEET	
	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 irrigations or sprays?		
Vaporizer?		
Humidifier?		
Do you take over-the-counter nose sprays and decongestants If yes, please list them:	?	

(continued)

•		
	YES	NO
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?		
If yes, does this interfere with your daily function or job performance?		
Have you seen a medical doctor for treatment of the breathing problem through your nose?		
Doctor's name		
Address		
Treatment dates		
What treatment was advised?		
Did you benefit from the treatment?		

REV 07/04/mat