Functional Nose Information Sheet

Do you have difficulty breathing through your nose? □ □

Do you experience sinus headaches? □ □

Are you a mouth breather? □ □

Do you experience sore throats and dry chapped lips as a result of breathing? □ □

Do you snore? □ □

Do you find that it is harder to breathe through your nose when laying 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:

Do you wake up at night due to breathing problems? □ □

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 this condition? □ □

Doctor’s name_________________________________

Address______________________________________

Treatment dates________________________________

What treatment was advised?
_______________________________________________

Did you experience relief from the treatment? □ □