Functional Nose Information Sheet

	YES	NO
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?	☐	☐

	YES	NO
Have you seen a medical doctor for treatment of this condition?	☐	☐

Doctor’s name________________________________

Address______________________________________

Treatment dates______________________________

What treatment was advised?

____

	YES	NO
Did you experience relief from the treatment?	☐	☐