Ali Totonchi, M.D

Functional Nasal Form

Patient's name: Date:

Do you have any difficulty breathing through your nose?

yes no

Do you experience headache?

yes no

Are you a mouth breather?

yes no

Do you snore?

yes no

Do you find it difficult to breath when lying down?

yes no

Do you use any of these?

-Nasal irrigation or sprays if yes, please list them:

yes no

-Vaporizer? Humidifier?

yes no

Do you wake up at night due to breathing problems?

yes no

Do you find yourself tired during day?

yes no

If yes, does it interfere with your daily job and performance?

yes no N/A

Do your breathing problems interfere with your activities like running, sport or other activities?

yes no N/A

Have you seen any doctor for breathing problem?

yes no

if yes. please name the Doctor and treatment:

Was the treatment successful?

yes no N/A