

Septoplasty Questionnaire

1. **Have you ever had any trauma to your nose?** Yes/no

If yes, please describe _____
_____, when _____?

2. **Do you routinely use nasal decongestants of any kind (prescription/over the counter)** Yes/no

If yes, please describe _____
_____, when _____?

3. **Do you routinely use nasal steroid sprays of any kind (prescription/over the counter)** Yes/no

If yes, please describe _____
_____, when _____?

4. **Have you sought treatment by any other physician for nasal breathing issues?** Yes/no

If yes, please describe _____
_____, when _____?

5. **Have you ever had any radiology or endoscopy exams for sinus/breathing issues?** Yes/no

If yes, please describe _____
_____, when _____?

6. **Have you ever been prescribed antibiotics for sinusitis or related issues?** Yes/no

If yes, please describe _____
_____, when _____?

In your own words, please describe the reason you feel that a Septoplasty surgery is medically needed _____

Name: _____ Signature: _____ Date: _____

Please note some insurance carriers will require documentation to support the necessity of surgery. It is the patient's responsibility to obtain documentation. We will notify you if any such documentation is needed.

How would you prefer we contact you if necessary? Email / Phone / Mail