

# PAIN SHEET

# CT SINUS EVALUATION

LAST NAME	FIRST	MIDDLE INIT.	AGE	TODAY'S DATE

1. Have you had a previous CT scan of your sinuses? \_\_\_\_\_

If so, where? \_\_\_\_\_

2. Have you had previous sinus surgery? \_\_\_\_\_

If so, when and what was done? \_\_\_\_\_

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