SINO-NASAL OUTCOME TEST

Name: _____ **Date:** _____

Considering how severe the problem is when you experience it and how often it happens, please rate each item below on how "bad" it is by circling the number that corresponds with how you feel using this scale →	NO PROBLEM	VERY MILD PROBLEM	MILD OR SLIGHT PROBLEM	MODERATE PROBLEM	SEVERE PROBLEM	PROBLEM IS AT ITS WORSE		5 MOST IMPORTANT
Nasal Symptoms:								
Nasal congestion/blockage	0	1	2	3	4	5		O
Runny nose	0	1	2	3	4	5		O
Sneezing	0	1	2	3	4	5		O
D**ecreased sense of smell/taste**	0	1	2	3	4	5		O
Post-nasal discharge	0	1	2	3	4	5		O
Thick nasal discharge	0	1	2	3	4	5		O
Eye Symptoms:								
Itchy, watery eyes	0	1	2	3	4	5		O
Swollen, sore eyes	0	1	2	3	4	5		O
Sleep Symptoms:								
Difficulty falling asleep	0	1	2	3	4	5		O
Wake up at night	0	1	2	3	4	5		O
Lack of a good night's sleep	0	1	2	3	4	5		O
wake up tired	0	1	2	3	4	5		O
Snoring	0	1	2	3	4	5		O
Ear Symptoms:								
Fullness/Pressure	0	1	2	3	4	5		O
Ringing	0	1	2	3	4	5		O
Dizziness	0	1	2	3	4	5		O
Pain	0	1	2	3	4	5		O
Decreased hearing	0	1	2	3	4	5		O
General Symptoms:								
Fatigue	0	1	2	3	4	5		O
Reduced Productivity	0	1	2	3	4	5		O
Reduced Concentration	0	1	2	3	4	5		O
Headache	0	1	2	3	4	5		O
Facial pain/pressure	0	1	2	3	4	5		O
Cough	0	1	2	3	4	5		O
Short of breath/wheezing	0	1	2	3	4	5		O
Diagnosed asthma	0	1	2	3	4	5		O
Practical Problems:								
Inconvenience of having to carry tissues	0	1	2	3	4	5		O
Need to rub nose/eyes	0	1	2	3	4	5		O
Need to blow nose	0	1	2	3	4	5		O
Bad breath	0	1	2	3	4	5		O
Emotional Consequences:								
Frustrated/Restless/Irritable	0	1	2	3	4	5		O
Depressed/Sad	0	1	2	3	4	5		O
Embarrassed	0	1	2	3	4	5		O

Please mark the most important items affecting your health (maximum of 5 items) _____