Name:_____ **Date of Birth:** _____/_____/_____

NASAL & SINUS QUESTIONNAIRE

Which of the following symptoms currently bother you? (Please mark **ALL** that apply)

_____ Facial pain/ Pressure How long? _____

_____ Decreased sense of smell How long? _____ Severity_____

_____ Facial congestion/ Fullness/ Pressure How long? _____

_____ Nasal discharge/ discolored drainage Color/ Thickness _____

_____ Nasal obstruction/ blockage RIGHT or LEFT side? (Please circle)

_____ Fever Highest temperature _____ How long? _____

_____ Headache Location _____ Severity?_____

_____ Sneezing/ Runny nose How long? _____

_____ Ear pain/ Pressure RIGHT or LEFT side? (Please circle)

_____ Decreased in hearing How long?_____ How long? _____

The above symptoms are: CONTINUOUS _____ or INTERMITTENT _____

How many sinus infections have you been treated for in the last year? _____

** Please name the MEDICATIONS you have taken for your symptoms.

- Antibiotics _____

How long? _____ Results? _____

How many rounds of antibiotics have you taken? _____

- Nasal Sprays? _____

How long? _____ Results? _____

OTHER medications? (E.G.: Antihistamines, Decongestants, ETC...) _____

_____

Name: _____ **Date of Birth:** ____/____/_____

Have you used NASAL SALINE IRRIGATION?_____ Results? _____

Have you had sinus surgery? YES _____ or NO _____

Have you been told you have nasal/ sinus polyps? YES_____, or NO _____

Do you have ENVIRONMENTAL ALLERGIES? YES _____ or NO _____

Have you been allergy tested? YES _____ NO_____ DATE ____/____/_____

Please list your sensitivities/ allergies: _____

_____.

Did your environment change prior to the onset of your problems? _____

If so, in what way? _____

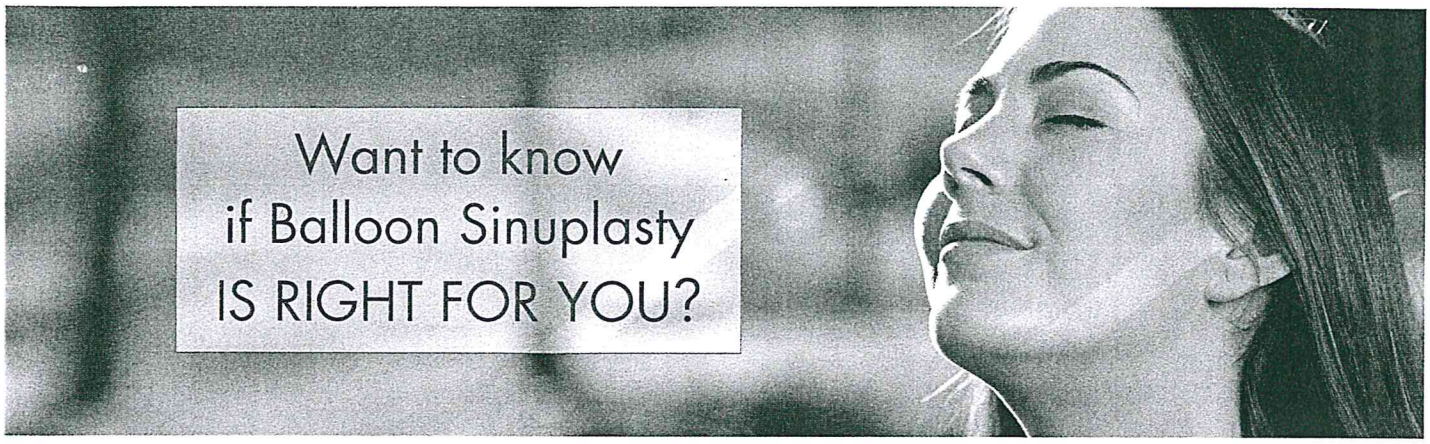
Have you had any previous testing? YES _____ NO_____

CT scan- date: _____ Location: _____

MRI - date: _____ Location: _____

Other- date: _____ Location: _____

***NURSE REVIEW _____



The following questionnaire is intended to help define your symptoms and provide valuable information and insights for your doctor. Answer the questions, rating to the best of your ability the problems you have experienced over the past two weeks.

Patient Name: _____

Sino-Nasal Outcome Test (SNOT-22)

Patient Phone: _____ Date: _____

1. Consider 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. 2. Please mark the most important items affecting your health (maximum of 5 items), right column.	No problem	Very mild problem	Mild or slight problem	Moderate problem	Severe problem	Problem as bad as it can be		5 most important items
1. Need to blow nose	0	1	2	3	4	5		○
2. Nasal Blockage	0	1	2	3	4	5		○
3. Sneezing	0	1	2	3	4	5		○
4. Runny nose	0	1	2	3	4	5		○
5. Cough	0	1	2	3	4	5		○
6. Post-nasal discharge	0	1	2	3	4	5		○
7. Thick nasal discharge	0	1	2	3	4	5		○
8. Ear fullness	0	1	2	3	4	5		○
9. Dizziness	0	1	2	3	4	5		○
10. Ear pain	0	1	2	3	4	5		○
11. Facial pain/pressure	0	1	2	3	4	5		○
12. Decreased sense of smell/taste	0	1	2	3	4	5		○
13. Difficulty falling asleep	0	1	2	3	4	5		○
14. Wake up at night	0	1	2	3	4	5		○
15. Lack of a good night's sleep	0	1	2	3	4	5		○
16. Wake up tired	0	1	2	3	4	5		○
17. Fatigue	0	1	2	3	4	5		○
18. Reduced productivity	0	1	2	3	4	5		○
19. Reduced concentration	0	1	2	3	4	5		○
20. Frustrated/restless/irritable	0	1	2	3	4	5		○
21. Sad	0	1	2	3	4	5		○
22. Embarrassed	0	1	2	3	4	5		○

SNOT-22 Developed from modification of SNOT-20 by National Comparative Audit of Surgery for Nasal Polyposis and Rhinosinusitis Royal College of Surgeons of England