I.D.: _____ Date.: _____

SINO-NASAL OUTCOME TEST (SNOT-20)

FREEMAN Health System
Ear, Nose, & Throat Center

Below you will find a list of symptoms and social/emotional consequesnces of your rhinosinusitis. We would like to know more about these problems and would appreciate your answering the following questions to the best of your ability. There are no right or wrong answers, and only you can provide us with this information. Please rate your problems as they have been over the past two weeks. Thank you for your participation. Do not hesitate to ask for assistance in necessary.

1. Considering how severe the problem is when you experience it and how frequently 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 as bad as it can be	5 most important items
1. Need to blow nose	0	1	2	3	4	5	❑
2. Sneezing	0	1	2	3	4	5	❑
3. Runny nose	0	1	2	3	4	5	❑
4. Cough	0	1	2	3	4	5	❑
5. Post-nasal discharge	0	1	2	3	4	5	❑
6. Thick nasal discharge	0	1	2	3	4	5	❑
7. Ear fullness	0	1	2	3	4	5	❑
8. Dizziness	0	1	2	3	4	5	❑
9. Ear pain	0	1	2	3	4	5	❑
10. Facial pain/pressure	0	1	2	3	4	5	❑
11. Difficulty falling asleep	0	1	2	3	4	5	❑
12. Wake up at night	0	1	2	3	4	5	❑
13. Lack of a good night's sleep	0	1	2	3	4	5	❑
14. Wake up tired	0	1	2	3	4	5	❑
15. Fatigue	0	1	2	3	4	5	❑
16. Reduced productivity	0	1	2	3	4	5	❑
17. Reduced concentration	0	1	2	3	4	5	❑
18. Frustrated/restless/irritable	0	1	2	3	4	5	❑
19. Sad	0	1	2	3	4	5	❑
20. Embarrassed	0	1	2	3	4	5	❑

2. Please mark the most important items affecting your health (maximum of 5 items) ----------^

PATIENT ALLERGY QUESTIONNAIRE

FREEMAN Health System
Ear, Nose, & Throat Center

NAME: _____

DATE OF BIRTH: _____

Complete the following section if there is a history of:

NASAL AND EYE SYMPTOMS

- ❑ Nasal congestion
- ❑ Sneezing
- ❑ Post nasal drip
- ❑ Itchy nose
- ❑ Itchy eyes
- ❑ Watery eyes
- ❑ Headache
- ❑ Ear problems
- ❑ NONE
- ❑ Other: _____

When are you symptomatic? ❑ Winter ❑ Spring ❑ Summer ❑ Fallr ❑ Year-round

When are your symptoms worst? ❑ Winter ❑ Spring ❑ Summer ❑ Fallr ❑ Year-round

Suspected or known causes of these symptoms:

- ❑ Colds
- ❑ Dust
- ❑ Odors/Fumes
- ❑ Cigarette smoke
- ❑ Mowing lawn
- ❑ Trees
- ❑ Weeds
- ❑ Grass
- ❑ Mold
- ❑ Dogs
- ❑ Cats
- ❑ Latex
- ❑ Foods
- ❑ Other: _____

Number of **sinus infections** treated in the past year: _____ ❑ None

History of **nasal polyps**: ❑ Yes ❑ No

PULMONARY SYMPTOMS

- ❑ Asthma
- ❑ Wheezing
- ❑ Bronchitis
- ❑ Cough
- ❑ Shortness of breath
- ❑ Chest tightness
- ❑ Tightness in throat
- ❑ Other: _____

Suspected or known causes of these symptoms:

- ❑ Colds
- ❑ Dust
- ❑ Odors/Fumes
- ❑ Cigarette smoke
- ❑ Mowing lawn
- ❑ Trees
- ❑ Weeds
- ❑ Grass
- ❑ Mold
- ❑ Dogs
- ❑ Cats
- ❑ Latex
- ❑ Foods
- ❑ Other: _____

Number of **colds** in the past year: _____ ❑ None