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**Sino-Nasal Outcome Test**

**(SNOT-20)**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Phone: (\_\_\_\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_ - \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_ / \_\_\_\_\_\_\_\_ /2017

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.

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Consider 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.Please mark the 5 most important items affecting your health. | **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 | O |
| 1. Sneezing
 | 0 | 1 | 2 | 3 | 4 | 5 | O |
| 1. Runny nose
 | 0 | 1 | 2 | 3 | 4 | 5 | O |
| 1. Cough
 | 0 | 1 | 2 | 3 | 4 | 5 | O |
| 1. Post-nasal discharge
 | 0 | 1 | 2 | 3 | 4 | 5 | O |
| 1. Thick nasal discharge
 | 0 | 1 | 2 | 3 | 4 | 5 | O |
| 1. Ear fullness
 | 0 | 1 | 2 | 3 | 4 | 5 | O |
| 1. Dizziness
 | 0 | 1 | 2 | 3 | 4 | 5 | O |
| 1. Ear Pain
 | 0 | 1 | 2 | 3 | 4 | 5 | O |
| 1. Facial Pain/Pressure
 | 0 | 1 | 2 | 3 | 4 | 5 | O |
| 1. Difficulty falling asleep
 | 0 | 1 | 2 | 3 | 4 | 5 | O |
| 1. Waking up at night
 | 0 | 1 | 2 | 3 | 4 | 5 | O |
| 1. Lack of sleep
 | 0 | 1 | 2 | 3 | 4 | 5 | O |
| 1. Wake up tired
 | 0 | 1 | 2 | 3 | 4 | 5 | O |
| 1. Fatigue
 | 0 | 1 | 2 | 3 | 4 | 5 | O |
| 1. Reduced productivity
 | 0 | 1 | 2 | 3 | 4 | 5 | O |
| 1. Reduced concentration
 | 0 | 1 | 2 | 3 | 4 | 5 | O |
| 1. Frustrated/Restless/Irritable
 | 0 | 1 | 2 | 3 | 4 | 5 | O |
| 1. Sad
 | 0 | 1 | 2 | 3 | 4 | 5 | O |
| 1. Embarrassed
 | 0 | 1 | 2 | 3 | 4 | 5 | O |

*How did you hear about our office?*

O Patient O Website O Hospital O Referred by Dr. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_