

Kenneth D Faw MD

SINO-NASAL OUTCOME TEST

Date: _____ **Pt Name:** _____ **DOB** _____

Symptom Severity

Please rate each statement listed below based on how bad the symptoms are that you experience by circling the number that corresponds to how you feel. Answer all questions please.	No problem	Very mild	Mild or slight problem	Moderate Problem	Severe	As bad as it can be	Check 5 most important
Need to blow nose	0	1	2	3	4	5	
Sneezing	0	1	2	3	4	5	
Runny Nose	0	1	2	3	4	5	
Nasal Obstruction	0	1	2	3	4	5	
Loss of smell/ taste	0	1	2	3	4	5	
Cough	0	1	2	3	4	5	
Post-nasal drip	0	1	2	3	4	5	
Thick nasal discharge	0	1	2	3	4	5	
Ear fullness	0	1	2	3	4	5	
Dizziness	0	1	2	3	4	5	
Ear pain	0	1	2	3	4	5	
Facial pain/ pressure	0	1	2	3	4	5	
Difficulty going to sleep	0	1	2	3	4	5	
Wake up at night	0	1	2	3	4	5	
Lack of good night's sleep	0	1	2	3	4	5	
Wake up tired	0	1	2	3	4	5	
Fatigue	0	1	2	3	4	5	
Reduced productivity	0	1	2	3	4	5	
Reduced concentration	0	1	2	3	4	5	
Frustrated/restless/irritable	0	1	2	3	4	5	
Sad	0	1	2	3	4	5	
Embarrassed	0	1	2	3	4	5	

How troublesome are your symptoms of rhinosinusitis?
(please mark on the line)

0 _____ 10

Not troublesome

Worst thinkable problem