ASHLAND ENT, ALLERGY & HEARING AID CENTER

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Sino-Nasal Outcome Test (SNOT-20)

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

□ Web □ Newspaper □ Billboard □ PostCard □ Patient Seminar □ Referred by family, friend or physician

PATIENT NAME: _____ DATE: _____ ACCT# _____

Office Visit _____ Allergy _____ Post OP _____ Surgery Date _____

1. 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. 2. Please mark the most important items affecting your health (maximum of 5 items)	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		0
2. Sneezing	0	1	2	3	4	5		0
3. Runny Nose	0	1	2	3	4	5		0
4. Cough	0	1	2	3	4	5		0
5. Post-nasal discharge	0	1	2	3	4	5		0
6. Thick nasal discharge	0	1	2	3	4	5		0
7. Ear fullness	0	1	2	3	4	5		0
8. Dizziness	0	1	2	3	4	5		0
9. Ear pain	0	1	2	3	4	5		0
10. Facial pain/pressure	0	1	2	3	4	5		0
11. Difficulty falling asleep	0	1	2	3	4	5		0
12. Wake up at night	0	1	2	3	4	5		0
13. Lack of sleep	0	1	2	3	4	5		0
14. Wake up tired	0	1	2	3	4	5		0
15. Fatigue	0	1	2	3	4	5		0
16. Reduced productivity	0	1	2	3	4	5		0
17. Reduced concentration	0	1	2	3	4	5		0
18. Frustrated/ restless/ irritable	0	1	2	3	4	5		0
19. Sad	0	1	2	3	4	5		0
20. Embarrassed	0	1	2	3	4	5		0

Have you heard about Balloon Sinuplasty™ Technology? □ Yes □ No

Have you been treated for 3 or more sinus infections within the past year? □ Yes □ No

THANK YOU!