Name: ____ DOB: _____________________ Date: ___________________

SINO-NASAL OUTCOME TEST (SNOT-22)

Please rate your problems as they have been over the past two weeks.

1. Considering 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: →	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**		○

Please mark the most important items affecting your health (maximum of 5 items)

<u>If you marked that you are experiencing symptoms in Sections A or B: Sinus and Nasal symptoms:</u>

- Have you experienced these symptoms for <u>12 or more consecutive weeks</u>?

  YES NO

- Have you experienced the symptoms for <u>10</u> or more days <u>four</u> or more times (with periods of no symptoms) in the last twelve months?

  YES NO

<u>If you marked that you are experiencing symptoms in *Section C: Ear Symptoms,* please answer the following:</u>

- Do you get these symptoms in one ear only or both ears?

LEFT EAR ONLY RIGHT EAR ONLY BOTH EARS

- How do these ear symptoms present themselves?:

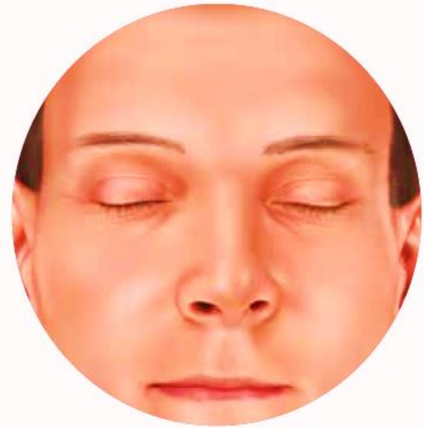
  With or without sinus symptoms

  With sinus symptoms only

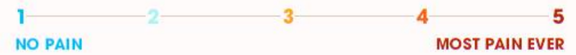
- Do you experience ear pain/pressure w/ atmospheric pressure change (driving on inclines, flying, diving)?

  YES NO

If you have facial pain or pressure, please place an "x" on the face below to show where you are feeling that pain or pressure:



Please **rate your current facial pain/pressure** on a scale of 1 to 5, 1 being no pain, and 5 being the most pain you have ever felt.



On what date did you first start experiencing these symptoms?

<u>Nasal Airway Obstruction</u>

- Do you use nasal strips (Breathe Right strips) during activity or sleep?

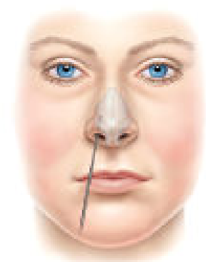
  YES NO

- Are you satisfied with the appearance of your nose?

  YES NO

COMMENTS:____

OFFICE/PHYSICIAN USE:



Lateral Wall
(Modified Cottle Test)

Left: ☐ Positive ☐ Negative
Right: ☐ Positive ☐ Negative

NOTES:

Septum
(Deviation Assessment) ☐ None ☐ Mild ☐ Moderate ☐ Severe

(Location of Deviation) ☐ Caudal ☐ Posterior ☐ Dorsal

NOTES:

Inferior Turbinates
(Inflamation Assessment)

Left: ☐ Hypertrophic ☐ Normal
Right: ☐ Hypertrophic ☐ Normal

NOTES: