

NAME (Last, First):

DOB:

Date:

Sino-Nasal Outcome Test (SNOT-22):

Below you will find a list of symptoms and social/emotional consequences 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 few weeks.

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	<input type="checkbox"/>
2. Sneezing	0	1	2	3	4	5	<input type="checkbox"/>
3. Runny nose	0	1	2	3	4	5	<input type="checkbox"/>
4. Nasal obstruction	0	1	2	3	4	5	<input type="checkbox"/>
5. Loss of smell or taste	0	1	2	3	4	5	<input type="checkbox"/>
6. Cough	0	1	2	3	4	5	<input type="checkbox"/>
7. Post-nasal discharge	0	1	2	3	4	5	<input type="checkbox"/>
8. Thick nasal discharge	0	1	2	3	4	5	<input type="checkbox"/>
9. Ear fullness	0	1	2	3	4	5	<input type="checkbox"/>
10. Dizziness	0	1	2	3	4	5	<input type="checkbox"/>
11. Ear pain	0	1	2	3	4	5	<input type="checkbox"/>
12. Facial pain/pressure	0	1	2	3	4	5	<input type="checkbox"/>
13. Difficulty falling asleep	0	1	2	3	4	5	<input type="checkbox"/>
14. Wake up at night	0	1	2	3	4	5	<input type="checkbox"/>
15. Lack of a good night's sleep	0	1	2	3	4	5	<input type="checkbox"/>
16. Wake up tired	0	1	2	3	4	5	<input type="checkbox"/>
17. Fatigue	0	1	2	3	4	5	<input type="checkbox"/>
18. Reduced productivity	0	1	2	3	4	5	<input type="checkbox"/>
19. Reduced concentration	0	1	2	3	4	5	<input type="checkbox"/>
20. Frustrated/restless/irritable	0	1	2	3	4	5	<input type="checkbox"/>
21. Sad	0	1	2	3	4	5	<input type="checkbox"/>
22. Embarrassed	0	1	2	3	4	5	<input type="checkbox"/>

Please check the most important items affecting your health (maximum of 5 items) _____ ↑