MODERN NOSE CLINIC

Allergy, Sinus, Snoring & Hearing

Patient's Name: _____ Date of Birth: _____

Sino-Nasal Outcome Test (SNOT-22) Today's Date: _____

The following questionnaire is intended to help define your symptoms and provide valuable information and insights for Dr. Skarada. Answer the questions, telling us how you feel today.

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. →	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) →