EAR, NOSE AND THROAT CONSULTANTS OF NEVADA

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Sino-Nasal Outcome Test (SNOT-22)

Patient name: ________________________________
Patient number: ______________________________
Date: ________________________________

1. 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. 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
Need to blow nose							
Sneezing							
Nasal obstruction							
Loss of smell or taste							
Cough							
Post-nasal discharge							
Thick nasal discharge							
Ear Fullness							
Dizziness							
Ear pain							
Facial pain/pressure							
Decreased sense of smell/taste							
Difficulty falling asleep							
Wake up at night							
Lack of a good night's sleep							
Wake up tired							
Fatigue							
Reduced productivity							
Reduced concentration							
Frustrated/restless/irritable							
Sad							
Embarrassed							