FLORIDA E.N.T. & Allergy

Breathe Well. Hear Well. Be Well.

Name: _____

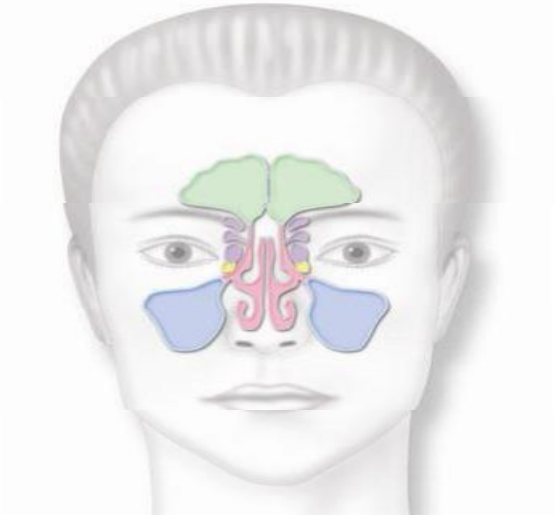
DOB: _____

Date: _____

Sino-Nasal Outcome Test (SNOT-20)

Total SNOT20 Score: _____

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



Please indicate the location of your pain/pressure by placing an "X".

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 low nose	0	1	2	3	4	5		O
2. Sneezing	0	1	2	3	4	5		O
3. Runny nose	0	1	2	3	4	5		O
4. Cough	0	1	2	3	4	5		O
5. Post-nasal discharge	0	1	2	3	4	5		O
6. Thick nasal discharge	0	1	2	3	4	5		O
7. Ear fullness	0	1	2	3	4	5		O
8. Dizziness	0	1	2	3	4	5		O
9. Ear pain	0	1	2	3	4	5		O
10. Facial pain / pressure	0	1	2	3	4	5		O
11. Difficulty falling asleep	0	1	2	3	4	5		O
12. Wake up at night	0	1	2	3	4	5		O
13. Lack of sleep	0	1	2	3	4	5		O
14. Wake up tired	0	1	2	3	4	5		O
15. Fatigue	0	1	2	3	4	5		O
16. Reduced productivity	0	1	2	3	4	5		O
17. Reduced concentration	0	1	2	3	4	5		O
18. Frustrated / restless / irritable	0	1	2	3	4	5		O
19. Sad	0	1	2	3	4	5		O
20. Embarrassed	0	1	2	3	4	5		O