FRONT

Direct Allergy
Treating the cause, not the symptoms.

ALLERGY PRE-ASSESSMENT

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. Please answer the following questions to the best of your ability. *Do not hesitate to ask for assistance if necessary.*

Considering how severe the problem is and how frequently it happens, rate each item by circling the number that corresponds with how you feel using this scale > > >	No Problem	Very Mild Problem	Mild/Slight Problem	Moderate Problem	Severe Problem	Problem as Bad as it Can Be
1 Need to blow nose	0	1	2	3	4	5
2 Sneezing	0	1	2	3	4	5
3 Runny Nose	0	1	2	3	4	5
4 Cough	0	1	2	3	4	5
5 Post-Nasal Discharge	0	1	2	3	4	5
6 Thick Nasal Discharge	0	1	2	3	4	5
7 Ear Fullness	0	1	2	3	4	5
8 Dizziness	0	1	2	3	4	5
9 Ear Pain/Pressure	0	1	2	3	4	5
10 Facial Pain/Pressure	0	1	2	3	4	5
11 Difficulty Falling Asleep	0	1	2	3	4	5
12 Wake Up at Night	0	1	2	3	4	5
13 Lack of a Good Night's Sleep	0	1	2	3	4	5
14 Wake Up Tired	0	1	2	3	4	5
15 Fatigue During the Day	0	1	2	3	4	5
16 Reduced Productivity	0	1	2	3	4	5
17 Reduced Concentration	0	1	2	3	4	5
18 Frustrated/Restless/Irritable	0	1	2	3	4	5
19 Sad	0	1	2	3	4	5
20 Embarrassed	0	1	2	3	4	5
21 Sense of Smell/Taste	0	1	2	3	4	5
22 Congestion/Obstruction of Nose	0	1	2	3	4	5

Continued on opposite side > > >

BACK

NASAL / SINUS WORKSHEET

1 Do you have nasal / sinus problems?
☐ Yes ☐ No

2 Do you have nasal obstruction / blockage / congestion?
☐ Yes ☐ No
if yes, which side is worse ☐ right ☐ left ☐ same

3 Do you use nasal sprays?
☐ Yes, Currently ☐ Yes, In the past ☐ Never

4 Which spray?
☐ Saline *(i.e. Ocean Spray)*
☐ Steroid *(i.e. Flonase, Nasonex)*
☐ Decongestant *(i.e. Afrin)*

5 How many sinus infections have you been treated for in the past year? _____

6 Have you had a recent CT scan or MRI for the sinuses?
☐ Yes, *date:* _____
☐ No

7 ASSOCIATED FACTORS *Check all that apply*
☐ Nasal drainage *(clear or colored)*
☐ Decreased sense of smell
☐ Facial pain/pressure/fullness
☐ Headache, *location:* _____
☐ Postnasal discharge

8 ALLERGIES *Check all that apply*
☐ Sneezing
☐ Itchy eyes or nose
☐ Watery eyes or nose

9 Have you ever been tested for allergies?
☐ Yes, *results:* _____
☐ No

10 Have you ever had allergy shots (allergy immunotherapy)?
☐ Yes, *for how long?* _____
When did you stop? _____
☐ No

Thank You for your participation.

Your Name: _____

Date of Birth: ___/___/___ **Today's Date:** ___/___/___

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*Result may vary by patient.

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