ENT SURGICAL ASSOCIATES, P.C.

RHINO-SINUSITIS QUESTIONAIRE

NAME____ DATE________________________

Below you will find a list of symptoms, functional limitations, and emotional consequences of your rhinosinusitis. We would like to know more about these problems and how they impact your life. There are no "right or wrong" answers, and only you can provide us with this information. Do not hesitate to ask our doctors or staff for help if necessary. Please refer to the following instructions and scales and circle the number that most accurately describes your experience.

MAGNITUDE SCALE - Considering how severe the problem is, when you get it and how frequently it happens, please rate each item below on how "bad" it is using the following scale.

0 = Not present / No problem
1 = Very mild problem
2 = Mild to slight problem
3 = Moderate problem
4 = Severe problem
5 = Problem is as "bad as it can be"

IMPORTANCE SCALE - For each item that has a magnitude of 1,2,3,4,please rate how important it is to you. Use the following after scale.

1 = Not important
2 = Somewhat important
3 = Moderately important
4 = Extremely important

NASAL SYMPTOMS	MAGNITUDE	IMPORTANCE
1. Stuffy / Blocked nose……………………………………………..	0 1 2 3 4 5 ___	1 2 3 4
2. Runny nose………………………………………………………..	0 1 2 3 4 5 ___	1 2 3 4
3. Sneezing…………………………………………………………..	0 1 2 3 4 5 ___	1 2 3 4
4. Decreased sense of smell or taste………………………………..	0 1 2 3 4 5 ___	1 2 3 4
5. Post-nasal discharge…………………………………………….	0 1 2 3 4 5 ___	1 2 3 4
6. Thick nasal discharge / Debris……………………………………..	0 1 2 3 4 5 ___	1 2 3 4
EYE SYMPTOMS		
7. Itchy, watery eyes……………………………………………….	0 1 2 3 4 5 ___	1 2 3 4
8. Swollen / Sore eyes………………………………………………	0 1 2 3 4 5 ___	1 2 3 4
SLEEP		
9. Difficulty getting to sleep…………………………………………..	0 1 2 3 4 5 ___	1 2 3 4
10. Wake up during the night ………………………………………………………	0 1 2 3 4 5 ___	1 2 3 4
11. Lack of a good night's sleep……………………………………….	0 1 2 3 4 5 ___	1 2 3 4
12. Wake up tired…………………………………………………….	0 1 2 3 4 5 ___	1 2 3 4
EAR SYMPTOMS		
13. Fullness…………………………………………………………..	0 1 2 3 4 5 ___	1 2 3 4
14. Ringing……………………………………………………………	0 1 2 3 4 5 ___	1 2 3 4
15. Dizziness…………………………………………………………	0 1 2 3 4 5 ___	1 2 3 4
16. Pain……………………………………………………………….	0 1 2 3 4 5 ___	1 2 3 4
17. Decreased hearing………………………………………………	0 1 2 3 4 5 ___	1 2 3 4

GENERAL SYMPTOMS

		MAGNITUDE	IMPORTANCE
18.	Fatigue / Worn out……………………………………………….	0 1 2 3 4 5 ___	1 2 3 4
19.	Reduced productivity……………………………………………	0 1 2 3 4 5 ___	1 2 3 4
20.	Poor concentration………………………………………………	0 1 2 3 4 5 ___	1 2 3 4
21.	Headache…………………………………………………………	0 1 2 3 4 5 ___	1 2 3 4
22.	Facial pain / Pressure…………………………………………..	0 1 2 3 4 5 ___	1 2 3 4
23.	Cough…………………………………………………………….	0 1 2 3 4 5 ___	1 2 3 4
24.	Shortness of breath………………………………………………..	0 1 2 3 4 5 ___	1 2 3 4

PRACTICAL PROBLEMS

		MAGNITUDE	IMPORTANCE
25.	Inconvenience of having to carry tissues / Handkerchief………..	0 1 2 3 4 5 ___	1 2 3 4
26.	Need to rub nose / Eyes…………………………………………..	0 1 2 3 4 5 ___	1 2 3 4
27.	Need to blow nose repeatedly…………………………………	0 1 2 3 4 5 ___	1 2 3 4
28.	Bad breath……………………………………………………….	0 1 2 3 4 5 ___	1 2 3 4

EMOTIONAL CONSEQUENCES

		MAGNITUDE	IMPORTANCE
29.	Frustrated, impatient, restless or irritable……………………….	0 1 2 3 4 5 ___	1 2 3 4
30.	Feeling depressed or sad………………………………………	0 1 2 3 4 5 ___	1 2 3 4
31.	Embarrassed by my symptoms………………………………….	0 1 2 3 4 5 ___	1 2 3 4

Please feel free to add any additional comments below. Thank you for your help.

Medications you are taking:____

____

Questions for your doctor:____

____

____

Instructions to attending physician:

Your signature below indicates that you have reviewed the information contained in the entire questionnaire and you have reviewed the pertinent or key findings with the patient and / or family. Key finding(s) must be summarized in your progress note, however the questionnaire may be referenced for additional details.

Dr. Signature____ Date________________________