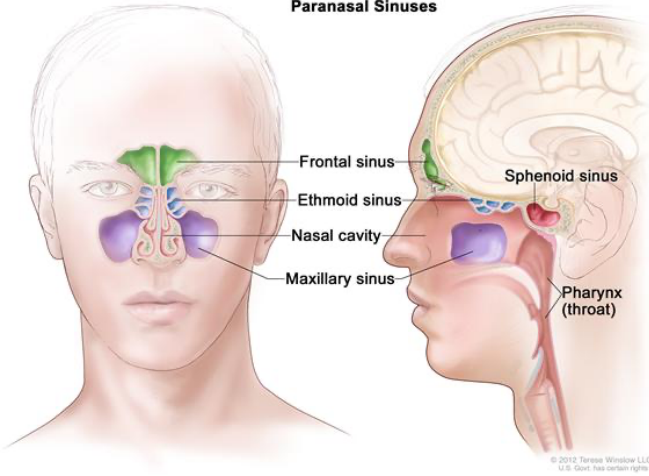


Paranasal Sinuses



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SINO-NASAL OUTCOME TEST

SNOT 22

Patient Name: _____ Date: _____

DO YOU HAVE A SENSE OF SMELL: YES _____ NO _____ TASTE: YES _____ NO _____

Consider how severe the problem is, how frequently it happens and rate those problems (based on the last two weeks)	No problem	Very mild problem	Slight Problem	Moderate Problem	Severe Problem	Problem as bad as it can be
Need to blow your nose	0	1	2	3	4	5
Sneezing	0	1	2	3	4	5
Runny nose	0	1	2	3	4	5
Cough	0	1	2	3	4	5
Post nasal discharge	0	1	2	3	4	5
Thick nasal discharge	0	1	2	3	4	5
Ear fullness	0	1	2	3	4	5
Dizziness	0	1	2	3	4	5
Ear pain/pressure	0	1	2	3	4	5
Facial pain/pressure	0	1	2	3	4	5
Difficulty falling asleep	0	1	2	3	4	5
Waking up at night	0	1	2	3	4	5
Lack of a good night sleep	0	1	2	3	4	5
Waking up tired	0	1	2	3	4	5
Fatigue during the day	0	1	2	3	4	5
Reduced productivity	0	1	2	3	4	5
Reduced concentration	0	1	2	3	4	5
Frustrated/restless/irritable	0	1	2	3	4	5
Sad	0	1	2	3	4	5
Embarrassed	0	1	2	3	4	5
Sense of smell/test	0	1	2	3	4	5
Blockage/congestion of nose	0	1	2	3	4	5
Headache	0	1	2	3	4	5
TOTAL EACH COLUMN						

GRAND TOTAL TODAY _____