



CEDARS-SINAI MEDICAL CENTER

SINO-NASAL OUTCOME TEST

___ Pre-Surgery Survey
___ Post-Surgery Survey

Patient Name: _____

Date: _____

Surgery Date: _____

Surgeon: _____

You will also be asked to complete a post-surgery survey again in 3 months, 6 months, and 12 months. We will be contacting you either by mail or e-mail. Please indicate the e-mail address you would like us to use: _____

Symptom Severity

Please rate each statement listed below based on how bad the symptoms are that you experience by circling the number that corresponds to how you feel. Answer all questions please.	No problem	Very mild	Mild or slight problem	Moderate Problem	Severe	As bad as it can be	Check the <u>one</u> most important symptom
Need to blow nose	0	1	2	3	4	5	
Sneezing	0	1	2	3	4	5	
Runny Nose	0	1	2	3	4	5	
Nasal Obstruction	0	1	2	3	4	5	
Loss of smell/ taste	0	1	2	3	4	5	
Cough	0	1	2	3	4	5	
Post-nasal drip	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	0	1	2	3	4	5	
Facial pain/ pressure	0	1	2	3	4	5	
Difficulty going to sleep	0	1	2	3	4	5	
Wake up at night	0	1	2	3	4	5	
Lack of good night's sleep	0	1	2	3	4	5	
Wake up tired	0	1	2	3	4	5	
Fatigue	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	

How troublesome are your symptoms of rhinosinusitis?

(please mark on the line)

0 _____ 10
Not troublesome Worst thinkable problem

When completed, please fax to (310) 423-0241, or mail to Cedars Sinai, 8635 W. Third St Suite 1070W Los Angeles, CA 90048. Thank You.