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Name ______________________
Phone______________________
Date of Birth_________________

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Sino-Nasal Outcome Test (SNOT 20)

1. Consider how severe the problem is 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		Most important items
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 drainage	0	1	2	3	4	5		◯
6.	Thick nasal discharge	0	1	2	3	4	5		◯
7.	Facial pain/Pressure	0	1	2	3	4	5		◯
8.	Ear Pain	0	1	2	3	4	5		◯
9.	Ear Fullness	0	1	2	3	4	5		◯
10.	Dizziness	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 sleep	0	1	2	3	4	5		◯
14.	Wake up tired	0	1	2	3	4	5		◯
15.	Fatigue	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		◯

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