

SINUSITIS OUTCOME MEASURE QUESTIONNAIRE

Patient Name: _____ DOB: _____ Date: _____

Dear Patient: In our ongoing efforts to help you with your sinus and nasal problems, we kindly ask that you complete this form at the beginning of EACH visit. We will use the information to better define, track, and treat your problems. Both you and we will find the information useful over time, and we appreciate your cooperation in the completion of the form.

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. Please rate your problems as they have been “RECENTLY”. Do not hesitate to ask our doctors or staff members for help if necessary. Please refer to the following instructions and scales and circle the number that most 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 0,1,2,3,4,5
please rate how important it is to you using the
following scale:

- 0= No problem
- 1= Not important
- 2= Somewhat important
- 3= Moderately important
- 4= Extremely important
- 5= Most important

Nasal Symptoms

- 1. Stuffy/blocked nose
- 2. Running nose
- 3. Sneezing
- 4. Decreased sense of smell or taste
- 5. Post nasal discharge
- 6. Thick nasal discharge/debris

Magnitude

- 0 1 2 3 4 5
- 0 1 2 3 4 5
- 0 1 2 3 4 5
- 0 1 2 3 4 5
- 0 1 2 3 4 5
- 0 1 2 3 4 5

Importance

- 0 1 2 3 4 5
- 0 1 2 3 4 5
- 0 1 2 3 4 5
- 0 1 2 3 4 5
- 0 1 2 3 4 5
- 0 1 2 3 4 5

Eye Symptoms

- 7. Itchy, watery eyes
- 8. Swollen, sore eyes

Magnitude

- 0 1 2 3 4 5
- 0 1 2 3 4 5

Importance

- 0 1 2 3 4 5
- 0 1 2 3 4 5

Sleep

- 9. Difficulty getting to sleep
- 10. Wake up during the night
- 11. Lack of a good night’s sleep
- 12. Wake up tired

Magnitude

- 0 1 2 3 4 5
- 0 1 2 3 4 5
- 0 1 2 3 4 5
- 0 1 2 3 4 5

Importance

- 0 1 2 3 4 5
- 0 1 2 3 4 5
- 0 1 2 3 4 5
- 0 1 2 3 4 5



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Ear Symptoms	Magnitude	Importance
13. Fullness	0 1 2 3 4 5	0 1 2 3 4 5
14. Ringing	0 1 2 3 4 5	0 1 2 3 4 5
15. Dizziness	0 1 2 3 4 5	0 1 2 3 4 5
16. Pain	0 1 2 3 4 5	0 1 2 3 4 5
17. Decreased hearing	0 1 2 3 4 5	0 1 2 3 4 5

General Symptoms	Magnitude	Importance
18. Fatigue/worn out	0 1 2 3 4 5	0 1 2 3 4 5
19. Reduced productivity	0 1 2 3 4 5	0 1 2 3 4 5
20. Poor concentration	0 1 2 3 4 5	0 1 2 3 4 5
21. Headache	0 1 2 3 4 5	0 1 2 3 4 5
22. Facial pain/pressure	0 1 2 3 4 5	0 1 2 3 4 5
23. Cough	0 1 2 3 4 5	0 1 2 3 4 5
24. Shortness of breath	0 1 2 3 4 5	0 1 2 3 4 5

Practical Problems	Magnitude	Importance
25. Inconvenience of having to carry tissues	0 1 2 3 4 5	0 1 2 3 4 5
26. Need to rub nose/eyes	0 1 2 3 4 5	0 1 2 3 4 5
27. Need to blow nose repeatedly	0 1 2 3 4 5	0 1 2 3 4 5
28. Bad breath	0 1 2 3 4 5	0 1 2 3 4 5

Emotional Consequences	Magnitude	Importance
29. Frustrated, impatient, restless or irritable	0 1 2 3 4 5	0 1 2 3 4 5
30. Feeling depressed or sad	0 1 2 3 4 5	0 1 2 3 4 5
31. Embarrassed by my symptoms	0 1 2 3 4 5	0 1 2 3 4 5

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

Medications you are taking:

Questions for your Doctor:
