SMOKY HILL
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SINUSITIS OUTCOME MEASURE QUESTIONNAIRE

Patient Name:__________________________DOB:___________________Date:_____________

Dear Patient: In our ongoing efforts to help you with your ear, nose, and throat 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 using the 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 is relevant to you, please rate how important it is to you following scale:

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

Nasal Symptoms	**Magnitude**	**Importance**
1. Stuffy/blocked nose	0 1 2 3 4 5	0 1 2 3 4 5
2. Running nose	0 1 2 3 4 5	0 1 2 3 4 5
3. Sneezing	0 1 2 3 4 5	0 1 2 3 4 5
4. Decreased sense of smell or taste	0 1 2 3 4 5	0 1 2 3 4 5
5. Post nasal discharge	0 1 2 3 4 5	0 1 2 3 4 5
6. Thick nasal discharge/debris	0 1 2 3 4 5	0 1 2 3 4 5

Eye Symptoms	**Magnitude**	**Importance**
7. Itchy, watery eyes	0 1 2 3 4 5	0 1 2 3 4 5
8. Swollen, sore eyes	0 1 2 3 4 5	0 1 2 3 4 5

Sleep	**Magnitude**	**Importance**
9. Difficulty getting to sleep	0 1 2 3 4 5	0 1 2 3 4 5
10. Wake up during the night	0 1 2 3 4 5	0 1 2 3 4 5
11. Lack of a good night's sleep	0 1 2 3 4 5	0 1 2 3 4 5
12. Wake up tired	0 1 2 3 4 5	0 1 2 3 4 5

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

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Throat Symptoms	Magnitude	Importance
18. Pain when swallowing	0 1 2 3 4 5	0 1 2 3 4 5
19. Difficulty swallowing	0 1 2 3 4 5	0 1 2 3 4 5
20. Lump in the throat	0 1 2 3 4 5	0 1 2 3 4 5
21. Frequent throat clearing	0 1 2 3 4 5	0 1 2 3 4 5
22. Phlegm	0 1 2 3 4 5	0 1 2 3 4 5

General Symptoms	Magnitude	Importance
23. Fatigue/worn out	0 1 2 3 4 5	0 1 2 3 4 5
24. Reduced productivity	0 1 2 3 4 5	0 1 2 3 4 5
25. Poor concentration	0 1 2 3 4 5	0 1 2 3 4 5
26. Headache	0 1 2 3 4 5	0 1 2 3 4 5
27. Facial pain/pressure	0 1 2 3 4 5	0 1 2 3 4 5
28. Cough	0 1 2 3 4 5	0 1 2 3 4 5
29. Shortness of breath	0 1 2 3 4 5	0 1 2 3 4 5

Practical Problems	Magnitude	Importance
30. Inconvenience of having to carry tissues	0 1 2 3 4 5	0 1 2 3 4 5
31. Need to rub nose/eyes	0 1 2 3 4 5	0 1 2 3 4 5
32. Need to blow nose repeatedly	0 1 2 3 4 5	0 1 2 3 4 5
33. Bad breath	0 1 2 3 4 5	0 1 2 3 4 5

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

Please provide your height and weight to the best of your knowledge for treatment with certain medications:

Height: ________________ Weight:_______________

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

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Medication Allergies:

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Medications you are taking:

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Questions for your Doctor:

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