

SNOT 22 SINO-NASAL OUTCOME TEST (22 QUESTIONS)

Patient Name: _____ Date: _____ DOB: _____

Considering how severe the problem is when you experience it and how often it happens, please rate each item below on how “bad” it is by circling the number that corresponds with how you feel.	No problem	Very mild problem	Mild or slight problem	Moderate problem	Severe problem	Problem as bad as it can be	Most important 5 items	
Need to blow my nose	0	1	2	3	4	5	<input type="checkbox"/>	
Nasal blockage	0	1	2	3	4	5	<input type="checkbox"/>	
Sneezing	0	1	2	3	4	5	<input type="checkbox"/>	
Runny nose	0	1	2	3	4	5	<input type="checkbox"/>	
Cough	0	1	2	3	4	5	<input type="checkbox"/>	
Post-nasal drip	0	1	2	3	4	5	<input type="checkbox"/>	
Thick nasal discharge	0	1	2	3	4	5	<input type="checkbox"/>	
Ear fullness	0	1	2	3	4	5	<input type="checkbox"/>	
Dizziness	0	1	2	3	4	5	<input type="checkbox"/>	
Ear pain	0	1	2	3	4	5	<input type="checkbox"/>	
Facial pain/pressure	0	1	2	3	4	5	<input type="checkbox"/>	
Decreased sense of smell/taste	0	1	2	3	4	5	<input type="checkbox"/>	
Difficulty falling asleep	0	1	2	3	4	5	<input type="checkbox"/>	
Wake up at night	0	1	2	3	4	5	<input type="checkbox"/>	
Lack of a good night’s sleep	0	1	2	3	4	5	<input type="checkbox"/>	
Wake up tired	0	1	2	3	4	5	<input type="checkbox"/>	
Fatigue	0	1	2	3	4	5	<input type="checkbox"/>	
Reduced productivity	0	1	2	3	4	5	<input type="checkbox"/>	
Reduced concentration	0	1	2	3	4	5	<input type="checkbox"/>	
Frustrated/restless/irritable	0	1	2	3	4	5	<input type="checkbox"/>	
Sad	0	1	2	3	4	5	<input type="checkbox"/>	
Embarrassed	0	1	2	3	4	5	<input type="checkbox"/>	
TOTAL SCORE								