estrella
EAR, NOSE AND THROAT, P.C.

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Patient Name: _____ Date: _____

1. Consider how severe the problem is when you experience it and how frequently it happens, please rate each item below on how "bad" it is by checking 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	5 most Important items
		0	1	2	3	4	5	
1	Need to Blow Nose							
2	Sneezing							
3	Runny Nose							
4	Cough							
5	Post-Nasal Drainage							
6	Thick Nasal Discharge							
7	Ear Fullness							
8	Dizziness							
9	Ear Pain							
10	Facial Pain/ Pressure							
11	Difficulty Falling Asleep							
12	Wake up at Night							
13	Lack of Sleep							
14	Wake up Tired							
15	Fatigue							
16	Reduced Productivity							
17	Reduced Concentration							
18	Frustrated, Restless, Irritable							
19	Sad							
20	Embarrassed							