SINO-NASAL OUTCOME TEST

Name____ Today's Date__________________________

Please rate your symptoms 0-5 (0 being no presence of symptom and 5 being the highest degree of symptom). Please consider the severity of symptoms when they are at their worst which may not be how they are affecting you today.

Itchy Eyes/Watery Eyes	0	1	2	3	4	5
Runny Nose	0	1	2	3	4	5
Itchy Nose	0	1	2	3	4	5
Sneezing	0	1	2	3	4	5
Diagnosed Asthma	0	1	2	3	4	5
Wheezing	0	1	2	3	4	5
Cough	0	1	2	3	4	5
Sore Throat	0	1	2	3	4	5
Post Nasal Drip	0	1	2	3	4	5
Thick Nasal Discharge	0	1	2	3	4	5
Smell/Taste Disorder	0	1	2	3	4	5
Nasal Congestion	0	1	2	3	4	5
Ear Pressure/Fullness	0	1	2	3	4	5