LOS ANGELES CENTER FOR
EAR, NOSE, THROAT AND ALLERGY

SNOT-20

This questionnaire is designed to help determine your symptoms and provide your doctor with valuable information about your sinus disease. Please answer the questions, rating to the best of your ability the problems you have experienced over the past two weeks.

Consider how severe the probem is when you experience it and how frequently it happens, please rate each item below on how "bad" it is by circling the number that corresponds with how you feel.						
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
1. Need to blow nose	0	1	2	3	4	5
2. Sneezing	0	1	2	3	4	5
3. Runny nose	0	1	2	3	4	5
4. Cough	0	1	2	3	4	5
5. Post-nasal Discharge	0	1	2	3	4	5
6. Thick Nasal Discharge	0	1	2	3	4	5
7. Ear Fullness	0	1	2	3	4	5
8. Dizziness	0	1	2	3	4	5
9. Ear pain	0	1	2	3	4	5
10. Facial pain/pressure	0	1	2	3	4	5
11. Difficulty falling asleep	0	1	2	3	4	5
12. Wake up at night	0	1	2	3	4	5
13. Lack of sleep	0	1	2	3	4	5
14. Wake up tired	0	1	2	3	4	5
15. Fatigue	0	1	2	3	4	5
16. Reduced productivity	0	1	2	3	4	5
17. Reduced concentration	0	1	2	3	4	5
18. Frustrated/restless/irritable	0	1	2	3	4	5
19. Sad	0	1	2	3	4	5
20. Embarrassed	0	1	2	3	4	5

Name_____ Email_____

Phone_____ Date_____ Total score ___/100