Cleveland Nasal Sinus & Sleep Center

Howard L. Levine, M.D., F.A.C.S

OUTCOME MEASURE QUESTIONNAIRE

Date: _____

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 accurately 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 on how "bad" it is using the following scale:

0= No present/no problems
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 has a magnitude of 1, 2, 3, or 4, please rate how important it is to you. Use the following scale:

1= Not important
2= Somewhat important
3= Moderately important
4= Extremely important

	MAGNITUDE	IMPORTANCE
Nasal Symptoms		
1. Stuffy/blocked nose.	0 1 2 3 4 5	1 2 3 4
2. Runny nose.	0 1 2 3 4 5	1 2 3 4
3. Sneezing.	0 1 2 3 4 5	1 2 3 4
4. Decreased sense of smell or taste. . . .	0 1 2 3 4 5	1 2 3 4
5. Post-nasal discharge.	0 1 2 3 4 5	1 2 3 4
6. Thick nasal discharge/debris.	0 1 2 3 4 5	1 2 3 4
Eye Symptoms		
7. Itchy, watery eyes.	0 1 2 3 4 5	1 2 3 4
8. Swollen, sore eyes.	0 1 2 3 4 5	1 2 3 4
Sleep		
9. Difficulty getting to sleep.	0 1 2 3 4 5	1 2 3 4
10. Wake up during the night.	0 1 2 3 4 5	1 2 3 4
11. Lack of a good night's sleep.	0 1 2 3 4 5	1 2 3 4
12. Wake up tired.	0 1 2 3 4 5	1 2 3 4

SEE OTHER SIDE

Ear Symptoms	**MAGNITUDE**	**IMPORTANCE**
13. Fullness	0 1 2 3 4 5	1 2 3 4
14. Ringing	0 1 2 3 4 5	1 2 3 4
15. Dizziness	0 1 2 3 4 5	1 2 3 4
16. Pain	0 1 2 3 4 5	1 2 3 4
17. Decreased hearing	0 1 2 3 4 5	1 2 3 4
General Symptoms		
18. Fatigue/worn out	0 1 2 3 4 5	1 2 3 4
19. Reduced productivity	0 1 2 3 4 5	1 2 3 4
20. Poor concentration	0 1 2 3 4 5	1 2 3 4
21. Headache	0 1 2 3 4 5	1 2 3 4
22. Facial pain/pressure	0 1 2 3 4 5	1 2 3 4
23. Cough	0 1 2 3 4 5	1 2 3 4
24. Short of breath	0 1 2 3 4 5	1 2 3 4
Practical Problems		
25. Inconvenience of having to carry tissues/ handkerchief	0 1 2 3 4 5	1 2 3 4
26. Need to rub nose/eyes	0 1 2 3 4 5	1 2 3 4
27. Need to blow nose repeatedly	0 1 2 3 4 5	1 2 3 4
28. Bad breath	0 1 2 3 4 5	1 2 3 4
Emotional Consequences		
29. Frustrated, impatient, restless or irritable	0 1 2 3 4 5	1 2 3 4
30. Feeling depressed or sad	0 1 2 3 4 5	1 2 3 4
31. Embarrassed by my symptoms.	0 1 2 3 4 5	1 2 3 4

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

MEDICATIONS YOU ARE TAKING: _____

QUESTIONS FOR YOUR DOCTOR: _____

_____

Instructions to Attending Physician:
Your signature below indicates that you have reviewed the information contained in the entire questionnaire and you have reviewed the pertinent or key findings with the patient and/or family. Key finding(s) must be summarized in your progress note, however the questionnaire may be referenced for additional details.

MD Signature_____ Date_____

Cleveland Nasal Sinus & Sleep Center – 29001 Cedar Road– Cleveland, Ohio 44124 – 440-684-9980