Total Nasal Symptom Score (TNSS)

Patient Name _____ Date _____

Email _____

Please help us better understand the impact of chronic rhinitis on your quality of life by completing the below. Over the past **4 weeks**, how much of a **problem** were the following symptoms for you?

Please mark the most correct response	No Symptoms	Mild *Symptoms present but easily tolerated*	Moderate *Symptoms present and bothersome, but tolerable*	Severe *Symptoms present and interfere with activities of daily living and/or sleep*
Nasal Congestion	0	1	2	3
Runny Nose	0	1	2	3
Nasal Itching	0	1	2	3
Sneezing	0	1	2	3

Do you experience constant post-nasal drip? Y N

Do you have a chronic cough? Y N

Ask your doctor about a non-surgical procedure that may provide you lasting relief for your runny nose.

Office Administration

Sum the answers the patient marked.

Patient's TNSS Score _____

1-4	Mild
5-8	Moderate
9-12	Severe

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