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Full service adult and pediatric ear, nose, throat, head and neck surgery, allergy, audiology and hearing aid clinic

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The following questionnaire is intended to help define your symptoms and provide valuable information and insights for your doctor. Answer the questions, rating to the best of your ability the problems you have experienced over the past two weeks.

Patient name: _____ Date of birth:_____ Date:_____

Consider how severe the problem is when you experience it and how often it happens. please rate each item below on how "bad" it is by circling the number that corresponds with how you feel using this scale. Please mark the most important items affecting your health (maximum of 5 items), in the right column.	No problem	Very mild problem	Mild or slight problem	Moderate problem	Severe problem	Problem as bad as it can be		5 most important items
1. Need to blow nose	0	1	2	3	4	5		◯
2. Nasal blockage	0	1	2	3	4	5		◯
3. Sneezing	0	1	2	3	4	5		◯
4. Runny nose	0	1	2	3	4	5		◯
5. Cough	0	1	2	3	4	5		◯
6. Post-nasal discharge	0	1	2	3	4	5		◯
7. Thick nasal discharge	0	1	2	3	4	5		◯
8. Ear fullness	0	1	2	3	4	5		◯
9. Dizziness	0	1	2	3	4	5		◯
10. Ear pain	0	1	2	3	4	5		◯
11. Facial pain/pressure	0	1	2	3	4	5		◯
12. Decreased sense of smell/taste	0	1	2	3	4	5		◯
13. Difficulty falling asleep	0	1	2	3	4	5		◯
14. Wake up at night	0	1	2	3	4	5		◯
15. Lack of a good night's sleep	0	1	2	3	4	5		◯
16. Wake up tired	0	1	2	3	4	5		◯
17. Fatigue	0	1	2	3	4	5		◯
18. Reduced productivity	0	1	2	3	4	5		◯
19. Reduced concentration	0	1	2	3	4	5		◯
20. Frustrated/restless/irritable	0	1	2	3	4	5		◯
21. Sad	0	1	2	3	4	5		◯
22. Embarrassed by symptoms	0	1	2	3	4	5		◯

Total _____

Please answer the following allergy screening questions to the best of your ability.

1. Do you have hay fever symptoms such as sneezing, watery nasal drainage and nasal itchiness?
   □ Yes □ No □ Maybe

2. Do you have chronic nasal congestion and/or post nasal drip?
   □ Yes □ No □ Maybe

3. Do your eyes itch, water, get red and/or swell?
   □ Yes □ No □ Maybe

4. Do you have asthma (wheezing), tight chest and/or chronic cough?
   □ Yes □ No □ Maybe

5. Do you have skin problems such as eczema, hives or itching?
   □ Yes □ No □ Maybe

6. Do you have chronic fatigue due to difficulty breathing, snoring, or a stuffy nose at night?
   □ Yes □ No □ Maybe

7. Are your symptoms worse seasonally?
   □ Yes □ No □ Maybe

8. Do your symptoms change when you go indoors or outdoors?
   □ Yes □ No □ Maybe

9. Are your symptoms worse after going to bed or in the morning on arising?
   □ Yes □ No □ Maybe

10. Are your symptoms worse when you come into contact with dust?
    □ Yes □ No □ Maybe

11. Are your symptoms worse around animals?
    □ Yes □ No □ Maybe

12. Do you have close blood relatives that suffer from allergies?
    □ Yes □ No □ Maybe

13. Have you taken antihistamines in the last 7 days? □ Yes □ No □ Maybe

14. Are you taking a beta blocker? □ Yes □ No □ Maybe

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