Patient Name: _____ DOB: _____ Date: _____ Email: _____

Patient Age Range: 21 & under 22-35 36-50 51-64 65 & over Insurance Provider: _____

Nasal Obstruction Symptom Evaluation (NOSE) Score

Please help us better understand the impact of **nasal airway obstruction** 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	Not a Problem	Mild Problem	Moderate Problem	Fairly Bad Problem	Severe Problem
Nasal congestion or stuffiness	0	1	2	3	4
Nasal blockage or obstruction	0	1	2	3	4
Trouble breathing through nose	0	1	2	3	4
Trouble sleeping	0	1	2	3	4
Unable to get enough air through nose during exercise or exertion	0	1	2	3	4

YOUR TOTAL _____

NOSE SCORE _____ (TOTAL x5)

5-25	30-50	55-75	80-100
Mild	Moderate	Severe	Extreme

Studies have shown that patients treated for nasal airway obstruction also demonstrated improvements in sleep-related symptoms. Trouble sleeping? Fill out the questions below.

Epworth Sleepiness Scale (ESS)

Please help us better understand the impact of **daytime sleepiness** on your quality of life by completing the below. How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? Even if you haven't done some of these things recently, try to work out how they would have affected you.

Please mark the most correct response	Would Never Doze	Slight Chance of Dozing	Moderate Chance of Dozing	High Chance of Dozing
Sitting and reading	0	1	2	3
Watching TV	0	1	2	3
Sitting, inactive in a public place (e.g. theatre or a meeting)	0	1	2	3
As a passenger in a car for an hour without a break	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after a lunch without alcohol	0	1	2	3
In a car, while stopped for a few minutes in traffic	0	1	2	3
Lying down to rest in the afternoon when circumstances permit	0	1	2	3

Daytime Sleepiness Level

YOUR TOTAL _____

0-5	6-10	11-12	13-15	16-24
Lower Normal	Higher Normal	Mild Excessive	Moderate Excessive	Severe Excessive

Are you interested in a minimally-invasive treatment that may enable you to have lasting relief from your symptoms? Y N

Physician or Staff to complete this section

Lateral Wall – Modified Cottle Test **Positive** **Negative**

Physician _____ Date _____

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Total Nasal Symptom Score (TNSS)

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 & 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

YOUR TOTAL ____

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

Do you experience frequent post-nasal drip? Y N Do you have a chronic cough? Y N

In a small study, patients treated for chronic rhinitis demonstrated improvements in both chronic rhinitis and migraine symptoms. If you also suffer from frequent headaches or migraines, please fill out the questions below.

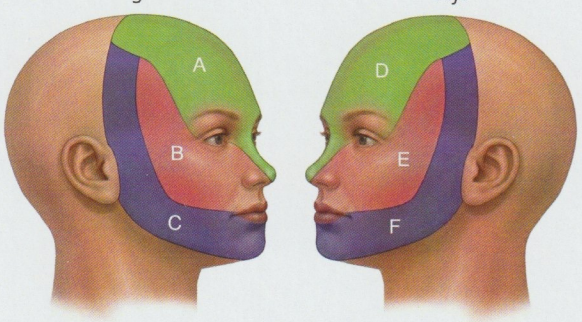
Migraine Symptom Screening (ICHD-3)

Please help us better understand the impact of **headaches** on your quality of life by completing the below.
Over the **past 4 weeks**, how often did you experience the following?

Please mark the most correct response				
I have headaches that last between 4–72 hours when untreated			Y	N
My headaches are usually on one side of my head			Y	N
My headaches have a pulsating or throbbing quality			Y	N
My headache pain is moderate to severe			Y	N
My headaches get worse with routine activity (walking, stairs)			Y	N
I experience nausea or vomiting during headaches			Y	N
Light and/or sound bothers me during headaches			Y	N
How many headache days per month on average?	<4	4-7	8-14	15+

Have you been diagnosed with migraines? Y N

Right *Left*



1. In the image to the left, please circle any lettered areas where you feel headache pain.
2. Of all the symptoms listed in this survey, please list the 3 most bothersome symptoms affecting your life.
   - _____
   - _____
   - _____

Are you interested in a minimally-invasive treatment that may enable you to have lasting relief from your symptoms? Y N

Physician _____ Date _____

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