CALIFORNIA SINUS CENTERS

Outcome Measure Questionnaire

Name: _____ Date of Birth: _____

We would like to know more about these problems and how they impact your life. There is no "right" or "wrong" answer; only you can provide us with this information. **Please rate your problems as they have been RECENTLY**.

Magnitude Scale

Considering how severe the problem is when it occurs and how frequently it happens, please rate each item below on how "bad" it is using the following scale:

0= Not 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"

1.	Stuffy / blocked nose ……	0	1	2	3	4	5
2.	Runny nose……..	0	1	2	3	4	5
3.	Decreased sense of smell or taste……	0	1	2	3	4	5
4.	Post-nasal discharge / thick nasal discharge / debris……..	0	1	2	3	4	5
5.	Difficulty sleeping ……..	0	1	2	3	4	5
6.	Ear fullness / ear pain …….	0	1	2	3	4	5
7.	Decreased hearing ……..	0	1	2	3	4	5
8.	Fatigue / worn out / decreased productivity……	0	1	2	3	4	5
9.	Facial pain / pressure / headache . …….	0	1	2	3	4	5
10.	Cough / short of breath……..	0	1	2	3	4	5
11.	Feeling depressed or sad / frustrated……..	0	1	2	3	4	5

****Please double check your list of medications <u>each visit</u> and notify the medical assistants of any changes****

Height: _____ Weight: _____ Blood pressure: _____

Medication changes: _____

What is your aim/goal for today's visit? _____

Questions for your Doctor: _____

Patient/Legal Guardian signature: _____ Date: _____