Patient Name: _____
Patient Phone: _____
Date: _____

Consider how severe the problem is when you experience it and how frequently it happens, please rate each item below on how "bad" it is by placing an "x" on the line that corresponds with how you feel.

1. Need to blow nose

__No problem __Very mild problem __Mild or slight problem __Moderate problem __Severe problem __Problem as bad as it can be

2. Sneezing

__No problem __Very mild problem __Mild or slight problem __Moderate problem __Severe problem __Problem as bad as it can be

3. Runny Nose

__No problem __Very mild problem __Mild or slight problem __Moderate problem __Severe problem __Problem as bad as it can be

4. Cough

__No problem __Very mild problem __Mild or slight problem __Moderate problem __Severe problem __Problem as bad as it can be

5. Post-nasal discharge

__No problem __Very mild problem __Mild or slight problem __Moderate problem __Severe problem __Problem as bad as it can be

6. Thick nasal discharge

__No problem __Very mild problem __Mild or slight problem __Moderate problem __Severe problem __Problem as bad as it can be

7. Ear fullness

__No problem __Very mild problem __Mild or slight problem __Moderate problem __Severe problem __Problem as bad as it can be

8. Dizziness

__No problem __Very mild problem __Mild or slight problem __Moderate problem __Severe problem __Problem as bad as it can be

9. Ear pain

__No problem __Very mild problem __Mild or slight problem __Moderate problem __Severe problem __Problem as bad as it can be

10. Facial pain / pressure

__No problem __Very mild problem __Mild or slight problem __Moderate problem __Severe problem __Problem as bad as it can be

11. Difficulty falling asleep

__No problem __Very mild problem __Mild or slight problem __Moderate problem __Severe problem __Problem as bad as it can be

12. Wake up at night

__No problem __Very mild problem __Mild or slight problem __Moderate problem __Severe problem __Problem as bad as it can be

13. Lack of sleep

__No problem __Very mild problem __Mild or slight problem __Moderate problem __Severe problem __Problem as bad as it can be

14. Wake up tired

__No problem __Very mild problem __Mild or slight problem __Moderate problem __Severe problem __Problem as bad as it can be

15. Fatigue

__No problem __Very mild problem __Mild or slight problem __Moderate problem __Severe problem __Problem as bad as it can be

16. Reduced productivity

__No problem __Very mild problem __Mild or slight problem __Moderate problem __Severe problem __Problem as bad as it can be

17. Reduced concentration

__No problem __Very mild problem __Mild or slight problem __Moderate problem __Severe problem __Problem as bad as it can be

18. Frustrated / restless / irritable

__No problem __Very mild problem __Mild or slight problem __Moderate problem __Severe problem __Problem as bad as it can be

19. Sad

__No problem __Very mild problem __Mild or slight problem __Moderate problem __Severe problem __Problem as bad as it can be

20. Embarrassed

__No problem __Very mild problem __Mild or slight problem __Moderate problem __Severe problem __Problem as bad as it can be

Please select the most important items affecting your health from the list above (maximum of 5 items).

1. _____

2. _____

3. _____

4. _____

5. _____

This form can be brought to our office at the time of your appointment or may be faxed to **(361) 573-5096**, Attention: Reception.