

Sinus Problems – Headaches – Allergies

Are you a candidate for Dr. Schneider's Endonasal Balloon Treatment?

The following questionnaire is intended to help define your symptoms, and provide valuable information and insights for us. Please answer the questions, rating to the best of your ability the problems you have experienced over the past **two weeks**. Return the questionnaire to Dr. Schneider.

Sinus Outcome Test

1. 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 circling the numbers that corresponds with how you feel using this scale:	No problem	Very mild problem	Mild or slight problem	Moderate Problem	Severe Problem	Problem as bad as it can be	5 most important items
2. Please mark the most important items affecting your health (maximum of 5 items).							
1. Need to blow nose	0	1	2	3	4	5	<input type="checkbox"/>
2. Sneezing	0	1	2	3	4	5	<input type="checkbox"/>
3. Runny nose	0	1	2	3	4	5	<input type="checkbox"/>
4. Cough	0	1	2	3	4	5	<input type="checkbox"/>
5. Post-nasal discharge	0	1	2	3	4	5	<input type="checkbox"/>
6. Thick nasal discharge	0	1	2	3	4	5	<input type="checkbox"/>
7. Ear fullness	0	1	2	3	4	5	<input type="checkbox"/>
8. Dizziness	0	1	2	3	4	5	<input type="checkbox"/>
9. Ear pain	0	1	2	3	4	5	<input type="checkbox"/>
10. Facial pain/pressure	0	1	2	3	4	5	<input type="checkbox"/>
11. Difficulty falling asleep	0	1	2	3	4	5	<input type="checkbox"/>
12. Wake up at night	0	1	2	3	4	5	<input type="checkbox"/>
13. Lack of sleep	0	1	2	3	4	5	<input type="checkbox"/>
14. Wake up tired	0	1	2	3	4	5	<input type="checkbox"/>
15. Fatigue	0	1	2	3	4	5	<input type="checkbox"/>
16. Reduced productivity	0	1	2	3	4	5	<input type="checkbox"/>
17. Reduced concentration	0	1	2	3	4	5	<input type="checkbox"/>
18. Frustrated/restless/irritable	0	1	2	3	4	5	<input type="checkbox"/>
19. Sad	0	1	2	3	4	5	<input type="checkbox"/>
20. Embarrassed	0	1	2	3	4	5	<input type="checkbox"/>

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