MVent
Memorial Village Ear Nose & Throat

Patient's Name _____ Today's Date _____

Patient's Occupation _____

REVIEW OF SYSTEMS Please check all the symptoms you have:

	GENERAL:		**EYES:**		**LUNGS:**
	Fever		Eye pressure / glaucoma		Shortness of breath
	Fatigue		Eyes itching		Dry cough
	Insomnia		Red eyes		Cough with sputum
	Restless sleep		Watery eyes		Cough with blood
	Snoring		Dry eyes		Chest tightness
	Sudden weight gain		Eye pain		Wheezing
	Sudden weight loss		Eye irritation		
			Vision problems		**HEART:**
	ENT:		Blurred vision		Chest pain or pressure
EARS:					High blood pressure
	Decreased hearing		**SKIN:**		Palpitations
	Ringing in ears		Swelling		
	Dizziness		Hives		**GASTROINTESTINAL:**
	Ear itching		Rash		Heartburn
	Popping		Skin itching		Nausea
	Fullness / Pressure		Eczema		Vomiting
	Ear pain		Suspicious lesions / moles		Diarrhea
	Excess Wax				Constipation
	Discharge from ears		**HEMATOLOGIC/LYMPHATIC:**		Abdominal pain
NOSE:			Easy bruising		Bloody/black/tarry stools
	Obstruction		Bleeding Disorders		
	Sneezing		Use of blood thinners		**UROLOGY:**
	Discharge from nose		Enlarged lymph nodes		Blood in urine
	Nose bleeds				Pain / burning when urinating
	Postnasal drainage		**HEAD:**		Unintentional urination
	Dryness		Headache		Frequent need to urinate
	Loss of smell		Dizziness		Sudden urge to urinate
	Frequent colds/sinus infections		Seizures		
	How many per year?_____				**MUSCULOSKELETAL:**
THROAT:			**MENTAL HEALTH:**		Excessive joint pain
	Frequent throat infections		Depression		Joint swelling
	Painful swallowing		Anxiety		
	Difficulty swallowing		High stress		
	Throat itching		Disorientation / confusion		
	Bad breath		Impaired memory		
	Dry mouth				
	Voice change		**ENDOCRINE:**		
	Hoarseness		Excessive sweating		
	Heartburn		Excessive thirst		
	Metallic taste		Excessive urination		
	Dental Disease		Cold intolerance		
			Heat intolerance		

MVent Memorial Village Ear Nose & Throat

Sino-Nasal Outcome Test (SNOT-22)

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 number that corresponds with how
2. Please mark the most important items affecting your health (maximum of 5 items).

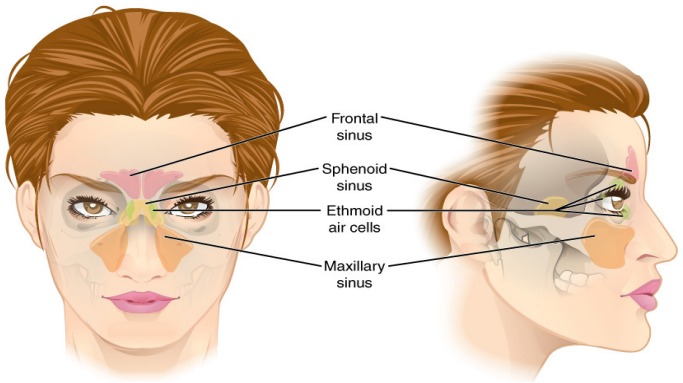
(Please circle)	No problem	Very mild problem	Mild problem	Moderate problem	Severe problem	Unbearable problem	5 most important items
Need to blow nose	0	1	2	3	4	5	
Nasal Blockage	0	1	2	3	4	5	
Sneezing	0	1	2	3	4	5	
Runny nose	0	1	2	3	4	5	
Cough	0	1	2	3	4	5	
Post-nasal discharge	0	1	2	3	4	5	
Thick nasal discharge	0	1	2	3	4	5	
Ear fullness	0	1	2	3	4	5	
Dizziness	0	1	2	3	4	5	
Ear pain	0	1	2	3	4	5	
Facial pain / pressure	0	1	2	3	4	5	
Decreased sense of smell / taste	0	1	2	3	4	5	
Difficulty falling asleep	0	1	2	3	4	5	
Wake up at night	0	1	2	3	4	5	
Lack of a good night's sleep	0	1	2	3	4	5	
Wake up tired	0	1	2	3	4	5	
Fatigue	0	1	2	3	4	5	
Reduced productivity	0	1	2	3	4	5	
Reduced concentration	0	1	2	3	4	5	
Frustrated / restless / irritable	0	1	2	3	4	5	
Sad	0	1	2	3	4	5	
Embarrased	0	1	2	3	4	5	

SNOT-22 Developed from modification of SNOT-20 by National Comparative Audit for Surgery for Nasal Polyposis and Rhinosinusitis, Royal College of Surgeons of England

Patient Name: _____

Date: _____

SCORE: ☐



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Nasal Obstruction Symptom Evaluation (NOSE) Score

Patient Name :

Email :

Date :

Please help us better understand the impact of nasal obstruction on your quality of life by completing the survey 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*	*Significant Problem*	*Severe Problem*
Nasal Congestion or Stuffiness	0	1	2	3	4
Nasal Blockage or Obstruction	0	1	2	3	4
Trouble Breathing Through My Nose	0	1	2	3	4
Trouble Sleeping	0	1	2	3	4
Unable to Get Enough Air Through My Nose During Exercise or Exertion	0	1	2	3	4

Significant and Severe Obstruction may indicate a narrow nasal airway. Ask your doctor about a non-surgical procedure that may provide you lasting relief for your stuffy nose.

Office Administration

Sum the answers the patient marked and multiply by 5 to base scale out of a possible score of 100 for analysis.

Symptoms Total _____

Multiply total by 5 and enter below.

Patient's N.O.S.E.Score _____

0	**No Obstruction**
5-25	**Mild Obstruction**
26-50	**Moderate Obstruction**
51-75	**Significant Obstruction**
76-100	**Severe Obstruction**