



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 each visit 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: _____