SOUTHEAST ENT

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Nasal Obstruction Symptom Evaluation (NOSE)

PATIENT NAME: _____ D.O.B: _____

PATIENT SIGNATURE: _____ DATE: _____

Please help us to better understand the impact of nasal obstruction on your quality of life by completing the following survey.

Over the past **1 month**, how much of a problem were the following conditions for you? (please **circle** the most correct response).

	Not a problem	Very mild problem	Moderate problem	Fairly bad 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
				TOTAL SCORE (POINTS X 5)	

Scoring Criteria:

Obstruction Symptom Intensity:
Mild (total score of 5-25)
Moderate (total score of 30-50)
Severe (total score of 55-75)
Extreme (total score of 80-100)