

LEXINGTON ENT SINUS OUTCOME REPORT



For Office Use ONLY:	
In Office	OR
Pre-OP	Post-OP

Circle the Doctor
Dr. Liberatore
Dr. Okun

Patient Name: _____

Pre-Op Date: _____

Post-Op Date: _____

This questionnaire is intended to help define your symptoms and provide valuable information to our doctors. Please answer the following questions regarding any problems you have experienced over the past two weeks.

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 you feel.

SYMPTOMS	No Problem	Very Mild Problem	Mild or Slight Problem	Moderate Problem	Severe Problem	Problem As Bad As It Can Be
Runny Nose	0	1	2	3	4	5
Cough	0	1	2	3	4	5
Nasal Congestion	0	1	2	3	4	5
Post-nasal Discharge	0	1	2	3	4	5
Thick nasal Discharge	0	1	2	3	4	5
Loss of Smell	0	1	2	3	4	5
Difficulty Breathing	0	1	2	3	4	5
Recurring Sinus Infection	0	1	2	3	4	5
Suffer from Allergies	0	1	2	3	4	5
Ear Fullness / Popping	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
Headaches	0	1	2	3	4	5
Numbness to the Face	0	1	2	3	4	5
Snoring	0	1	2	3	4	5
Lack of Sleep	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