Nasal Obstruction Symptom Evaluation (NOSE) Score

Patient Name ______________________ Date ____________

Email ______________________

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

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1244 Boylston St, Suite 303
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Tel 617-383-6800 Fax 617-383-6801

Date: ________ **New Patient Registration Form** **Acct#_________**

Demographics:

Patient's Last Name: ______________________________ First Name: ______________________________

Social Security # (SSN): ___________-__________-___________ Male ☐ Female ☐

Street Address: ____ Apt #: _______________

City: ______________________________ State: _____________ Zip Code: ___________________

Home Phone: _____________________ Business Phone: _______________________

Mobile/Other: Phone: ____________________________ Birthdate: _______/________/________

Marital Status: ☐ Married ☐ Divorced ☐ Single **Email:**____

Emergency Contact: Name: ____________________________________Relationship:______________________

Best contact telephone#: ______________________________________

Insurance Information:

Primary Insurance: ____________________________ **Secondary Insurance:** _________________________

Membership ID# ______________________________ Membership ID# ____________________________

Carrier's Name and DOB: ________________________ Carrier's Name and DOB: ______________________

Relationship to patient: __________________________ Relationship to patient: _______________________

Referral Information:

Who referred you to our office today? How did you hear about our practice?

____

Primary Care Physician:

Name: ________________________________ Address: ____

Telephone #: _______________________________________ Fax #: _________________________________

Please list names of any ADDITIONAL PHYSCIANS that should receive notes from our office

1. Name: ________________________________ Address: ____

   Telephone ____________________________ Specialty: _______________________________________

2. Name: ________________________________Address:____

   Telephone: ______________________________Specialty:____

Acct# ___________

Background Information

Please check as appropriate. **Federal Government Information Requirement**

Preferred Language: ☐ English ☐ French ☐ Japanese ☐ Spanish ☐ Chinese ☐ Other ______________________

Patient Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American

☐ Native Hawaiian or other Pacific Islander ☐ Caucasian/White ☐ Other/Unspecified

Patient Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Other/Unspecified

Social History

Alcohol Use: ☐ Never ☐ Moderate ☐ Occasionally ☐ Social # Drinks per week: _______

Exercise Regularly: ☐ Yes ☐ No

Exposure to Fumes, Dust, Solvents or Airborne Particles: ☐ Yes ☐ No ☐ none known

Recreational Drug Use: ☐ Never ☐ Former ☐ Current

Smoking History: ☐ **Current** Every Day ☐ Current Some Days ☐ Former Smoker ☐ Never Smoker

Of Years of Active Smoking: _______ Years since quitting: ________

Other Tobacco Use? (Pipe, Cigars, Chew): __________________________

Pharmacy Information

Local Pharmacy Name: ____

Street Address: ____

City: ______________________ _______________ State: _________ Zip: _________________________________

Phone #: ______________________________________ _______ Fax # ____

Mail Order Pharmacy Name: __________________________________ Mail Order ID: ______________________

Telephone # _______________________________ Fax #: ___________________________________

Pharmacy Preference (please choose) Local Pharmacy: ☐ Mail Order: ☐

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Reason for TODAY's visit: ______________________________

Acct # ________

Surgical History

Have you had a tonsillectomy? Yes No Year: ______________

Cancer: Specify ______________________________

Cardiac: Specify ______________________________

Cosmetic: Specify ______________________________

Ear Surgery: Specify ______________________________

Nose Surgery: Specify ______________________________

Throat Surgery: Specify ______________________________

Other Surgery: ______________________________

Family History

Illness/Condition	Father	Mother	Brother	Sister
Family History Unknown: Check box				
Abdominal Aortic Aneurysm				
Alzheimer's Disease				
Behavioral/Emotional Health				
Bleeding Disorders				
Brain/Nervous System				
Cancer				
Diabetes				
Hearing Loss				
Heart/Cardiovascular				
Genetic Disorders				
Migraines				
Respiratory Disorders				
Stroke				

Have you ever had a pneumonia immunization? Please circle one: Yes No Unknown

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Acct # __________

Past Medical History

(Check the box to the left of the condition that you are currently being treated for or have been treated for in the past)

	Allergies (Seasonal/Environment)		Deep Vein Thrombosis (DVT)		Low Blood Pressure
	Anemia		Depression		Lupus
	Angina		Dermatologic (Skin)Disease		Lyme Disease
	Acid Reflux		Diabetes		Lymphoma
	Asthma		Diverticulosis		Melanoma
	Atrial Fibrillation		Eye Disease		Mitral Valve Prolapse
	Auto-Immune Disease		Gallbladder Problems		Myocardial Infarction
	Behavioral Disorder		Gastrointestinal/GI Problems		Neurological Problems
	Bleeding Disorder		GERD/Reflux		Neuropathy
	Blood Clots		Hepatitis		Pneumonia
	Cancer		Head Injuries		Renal Disease
	Chronic Fatigue Syndrome		Headaches (migraine, cluster)		Rhinitis
	Cardiovascular (Heart Disease)		Hearing Loss		Seizure Disorder
	Chronic Heart Failure (CHF)		High Blood Pressure (Hypertension)		Sinus Problems/Sinusitis
	Congenital Heart Disease		High Cholesterol		Transient Ischemic Attack (TIAs)
	COPD/Emphysema		HIV/AIDS		Thyroid Disease
	Coronary Heart Disease		Insomnia		Tuberculosis
	Crohns Disease		Kidney/Urinary Bladder Problems		Ulcers (other)
	Cerebral Vascular Accident (CVA)		Liver Disease		Ulcers (stomach)

None of the above applies: ☐ check here

Review of Symptoms (ROS):

Identify which if any of the following you are currently experiencing:

√		√		√	
	Abdominal Pain		Frequent Nose Bleeds		Rash
	Anxiety		Headache		Shortness of Breath
	Cough		Heartburn		Skin Lesions
	Depression		Hoarseness		Sore throat
	Difficulty Hearing		Joint/Muscle Pain		Vision changes
	Difficulty Sleeping		Nausea		Weight gain/loss
	Difficulty Swallowing		Noises in Ear/Head		Wheezing
	Fainting		Pregnant		

Other Symptom(s) Not Listed: ____

____

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Acct # _______

Medication History

Please list all medications that you're taking including over-the-counter medications, vitamins and other treatments. Please attach your medication list if more convenient.

Name of Medication Include over the counter medications	Dosage (mg/units/puffs/drops)

Patient reviewed and acknowledges that they are not taking any medications at this time: ☐ check here

Drug, Food and Latex Allergies

Drug Allergies: ☐ No ☐ Yes

If yes, please list Drug name and reaction:

Drug Name: ______________________ Reaction ______________________

Drug Name: ______________________ Reaction: ______________________

Drug Name: ______________________ Reaction: ______________________

Latex Allergy: ☐ No ☐ Yes Reaction: ______________________

Shellfish Allergy: Yes ☐ **No** ☐

Other Food Allergies: ______________________

Patient/Physician Acknowledgement Signatures

Patient Signature: ______________________ **Date:** __________

Physician Signature: ______________________ **Date:** __________

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Name: ______________ Date: ______________ ACCT# ______________

SINO-NASAL OUTCOME TEST (SNOT-22)

1. Directions: Circle corresponding number (1,2,3,4,5). Considering 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 using this scale:	No problem	Very mild problem	Mild or slight problem	Moderate Problem	Severe Problem	Problem as bad as it can be
1. Need to blow nose	0	1	2	3	4	5
2. Sneezing	0	1	2	3	4	5
3. Runny nose	0	1	2	3	4	5
4. Nasal obstruction	0	1	2	3	4	5
5. Loss of smell or taste	0	1	2	3	4	5
6. Cough	0	1	2	3	4	5
7. Post - nasal discharge	0	1	2	3	4	5
8. Thick nasal discharge	0	1	2	3	4	5
9. Ear fullness	0	1	2	3	4	5
10. Dizziness	0	1	2	3	4	5
11. Ear pain	0	1	2	3	4	5
12. Facial pain/pressure	0	1	2	3	4	5
13. Difficulty falling asleep	0	1	2	3	4	5
13. Wake up at night	0	1	2	3	4	5
15. Lack of a good night's sleep	0	1	2	3	4	5
16. Wake up tired	0	1	2	3	4	5
17. Fatigue	0	1	2	3	4	5
18. Reduced productivity	0	1	2	3	4	5
19. Reduced concentration	0	1	2	3	4	5
20. Frustrated/restless/irritable	0	1	2	3	4	5
21. Sad	0	1	2	3	4	5
22. Embarrassed	0	1	2	3	4	5

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Name:______________________________   Today's date: ____________

Date of Birth:____________________

Epworth Sleepiness Scale

Answer how likely are you to doze off or fall asleep in the following situations.

Answer how you felt over the past week or so.

0 = Would never doze

1 = Slight chance of dozing

2 = Moderate chance of dozing

3 = High chance of dozing

Number	Question
________	1. Sitting and reading
________	2. Watching TV
________	3. Sitting inactive in a public place (e.g. theater or meeting)
________	4. As a passenger in a car for an hour ride without a break
________	5. Lying down to rest in the afternoon, when able
________	6. Sitting and talking to someone
________	7. Sitting quietly after a lunch, without alcohol
________	8. In a car, while stopped for a few minutes in traffic