



Nasal Obstruction and Septoplasty Effectiveness

Name: _____ Date: _____ Account Number: _____

This questionnaire provides valuable information we can use to help tailor a treatment plan specific to you. Please answer each question by marking the most appropriate response based on your symptoms over the past **month**. Thank you for your participation.

Over the past month, how much of a problem were the following symptoms.	Not a problem	Very mild problem	Moderate problem	Bad problem	Severe problem
1. Nasal congestion or stuffiness	0	1	2	3	4
2. Nasal blockage or obstruction	0	1	2	3	4
3. Trouble breathing through my nose	0	1	2	3	4
4. Trouble sleeping	0	1	2	3	4
5. Unable to get enough air through my nose during exercise or exertion	0	1	2	3	4
Line Total					

Total Score

(Line total x20) _____