Nasal Obstruction Symptom Evaluation (NOSE) Instrument

Participant ID: _____ Visit Date: ____/____/_____ Visit: _____

➔ **To the Patient:** Please help us to better understand the impact of nasal obstruction on your quality of life by **completing the following survey**. Thank You!

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*
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

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NOSE SCALE ADMINISTRATION

1. Have patient complete the questionnaire as indicated by circling the response closest to describing their current symptoms.

2. Sum the answers the patient circles and multiply by 5 to base the scale out of a possible score of 100 for analysis.