



GARY A. INCAUDO, M.D.
NICOLE HICKS, PA-C

145 Mission Ranch Boulevard, Suite 110
Chico, California 95926
T 530.896.2200
F 530.896.2209

RHINOSINUSITIS ASSESSMENT

Patient Name: _____ Date: _____

It is important for your doctor to know what **nasal or sinus symptoms** you experience and how they affect you. **Please mark the scale for each question with an "X" to indicate the severity of symptoms that you are experiencing using the following guidelines:**

None = No symptoms to occasional or limited episodes

Mild = Steady symptoms but easily tolerated

Bothersome = Symptoms are hard to tolerate; may interfere with activities of daily living and/or sleep

Severe = Symptoms are so bad that you cannot function all the time

1. How would you rate the **overall severity of your symptoms**?

None Mild Bothersome Severe
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2. How would you rate the **severity of each individual symptom** listed below?

	None	Mild	Bothersome	Severe
<i>Nasal blockage or congestion</i>	-----			
<i>Nasal drainage</i>	-----			
<i>Pain or pressure in your face</i>	-----			
<i>Headache</i>	-----			
<i>Fatigue</i>	-----			
<i>Decreased sense of smell</i>	-----			
<i>Pain or pressure in your ear(s)</i>	-----			
<i>Cough</i>	-----			
<i>Halitosis (bad breath)</i>	-----			
<i>Dental pain</i>	-----			
<i>Fever</i>	-----			

3. How would you rate the **impact of your symptoms on your quality of life**?

None Mild Bothersome Severe
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