FAIRFAX ENT & FACIAL PLASTIC SURGERY

Nasal Obstruction and Septoplasty Effectiveness Scale

Physician AAO-HNS#: _____ Today's Date: _____

Patient ID: _____ Patient Name: _____

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

Over the past ***ONE month***, how much of a **problem** were the following conditions for you?

Please select 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

TOTAL SCORE:	**0**

Nasal Obstruction Symptom Evaluation Scale