Are You a Candidate for Balloon Sinuplasty?

Name: _____ Date: _____

Next to each symptom, enter the number that best describes how you feel.

Symptom	No problem	Very mild problem	Mild problem	Moderate problem	Severe problem	Unbearable problem	
Need to blow nose	0	1	2	3	4	5	#
Nasal Blockage	0	1	2	3	4	5	#
Sneezing	0	1	2	3	4	5	#
Runny nose	0	1	2	3	4	5	#
Cough	0	1	2	3	4	5	#
Post-nasal discharge	0	1	2	3	4	5	#
Thick nasal discharge	0	1	2	3	4	5	#
Ear fullness	0	1	2	3	4	5	#
Dizziness	0	1	2	3	4	5	#
Ear pain	0	1	2	3	4	5	#
Facial pain/pressure	0	1	2	3	4	5	#
Decreased sense of smell/taste	0	1	2	3	4	5	#
Difficulty falling asleep	0	1	2	3	4	5	#
Wake up at night	0	1	2	3	4	5	#
Lack of a good night's sleep	0	1	2	3	4	5	#
Wake up tired	0	1	2	3	4	5	#
Fatigue	0	1	2	3	4	5	#
Reduced productivity	0	1	2	3	4	5	#
Reduced concentration	0	1	2	3	4	5	#
Frustrated/restless/irritable	0	1	2	3	4	5	#
Sad	0	1	2	3	4	5	#
Embarrassed	0	1	2	3	4	5	#

After you've filled this survey out, please bring it to your doctor to discuss the results and your specific symptoms

TOTAL	#

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