Ear, Nose, & Throat Consultants, Inc.

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Rhinoconjunctivitis Quality of Life Questionnaire

Please complete all questions by circling the number that best describes how you have been doing during the last 2 weeks, as a result of your eye/ear/nose symptoms.

Patient's Name: _____

Date: _____/_____/_____

DOB: _____/_____/_____

SLEEP: How troubled have you been by each of these sleep problems during the last week as a result of your eye/ear/nose symptoms

Not troubled	**Hardly troubled at all**	**Some-what troubled**	**Moderately troubled**	**Quite a bit troubled**	**Very troubled**	**Extremely troubled**

Difficulty getting to sleep 0 1 2 3 4 5 6 Waking up during the night 0 1 2 3 4 5 6 Lack of a good night's sleep 0 1 2 3 4 5 6

NON-HAY FEVER SYMPTOMS: How troubled have you been by each of these sleep problems during the last week as a result of your eye/ear/nose symptoms

Not troubled	**Hardly troubled at all Some-what**	**troubled Moderately troubled**	**Quite a bit troubled Very**	**troubled Extremely troubled**

Fatigue 0 1 2 3 4 5 6 Thirst 0 1 2 3 4 5 6 Reduced productivity 0 1 2 3 4 5 6 Tiredness 0 1 2 3 4 5 6 Poor Concentration 0 1 2 3 4 5 6 Headache 0 1 2 3 4 5 6 Worn out 0 1 2 3 4 5 6

Page 2 Quality of Life Questionnaire Name: _____ **PRACTICAL PROBLEMS:** How troubled have you been by each of these symptoms during the week?

Inconvenience of	having to	**troubled**	**Some-what**	**troubled**	**Very**	**troubled**
	Not	**Hardly**	**troubled**	**Quite a bit**	**troubled**	
		troubled at all	**Moderately**	**troubled**	**Extremely**	

Carry tissues/handkerchiefs 0 1 2 3 4 5 6 Need to rub nose/eye 0 1 2 3 4 5 6

Need to blow your nose
repeatedly 0 1 2 3 4 5 6 **NASAL SYMPTOMS:** How troubled have you been by each of these symptoms during the week?

Not troubled	**Hardly troubled at all**	**Some-what troubled**	**Moderately troubled**	**Quite a bit troubled**	**Very troubled**	**Extremely troubled**

Stuffy blocked nose 0 1 2 3 4 5 6 Runny nose 0 1 2 3 4 5 6 Sneezing 0 1 2 3 4 5 6 Itchy nose 0 1 2 3 4 5 6

PRACTICAL SYMPTOMS: How troubled have you been by each of these symptoms during the week?

		troubled	**Some-what**	**troubled**	**Very**	**troubled**
	Not	**Hardly**	**troubled**	**Quite a bit**	**troubled**	
		troubled at all	**Moderately**	**troubled**	**Extremely**	

Itchy eyes 0 1 2 3 4 5 6 Watery eyes 0 1 2 3 4 5 6 Sore eyes 0 1 2 3 4 5 6 Swollen eyes 0 1 2 3 4 5 6

ACTIVITIES THAT HAVE BEEN LIMITED BY EYE/EAR/NOSE SYMPTOMS DURING THE PREVIOUS WEEK:
How troubled have you been by each of these symptoms during the week?

	activities at home	**troubled at all**	**Quite a bit troubled**	**troubled**
	Not troubled	**Some-what troubled**	**Very troubled**	
Regular	**Hardly**	**Moderately troubled**	**Extremely**	

And work (your occupation 0 1 2 3 4 5 6 Or tasks you have to do
regularly around your home

Social activities (e.g. activities
with your family/friends playing 0 1 2 3 4 5 6 with children and pets, sex,
hobbies)

Outdoor activities (e.g. gardening,
mowing the lawn, sitting 0 1 2 3 4 5 6 outdoors, sports, going for a walk)

EMOTIONAL: How often during the last week have you been troubled by these emotions as a result
of your eye/nose/ear symptoms?

Not troubled	**Hardly troubled at all**	**Some-what troubled**	**Moderately troubled**	**Quite a bit troubled**	**Very troubled**	**Extremely troubled**

Frustrated 0 1 2 3 4 5 6 Impatient or Restless 0 1 2 3 4 5 6 Irritable 0 1 2 3 4 5 6

Embarrassed by your 0 1 2 3 4 5 6 Symptoms

Page 4 Quality of Life Questionnaire Name: _____ **SINUS SYMPTOMS:** How troubled have you been by each

of these symptoms during the week?

Not troubled	**Hardly troubled at all**	**Some-what troubled**	**Moderately troubled**	**Quite a bit troubled**	**Very troubled**	**Extremely troubled**

Head/sinus/tooth tenderness 0 1 2 3 4 5 6 Face/sinus/tooth pressure 0 1 2 3 4 5 6

Ear pain, blockage, fullness
or stuffiness 0 1 2 3 4 5 6 Discolored nasal discharge 0 1 2 3 4 5 6

Postnasal drip, drainage into
throat 0 1 2 3 4 5 6 Sore or scratch throat 0 1 2 3 4 5 6 Daytime cough, throat clearing 0 1 2 3 4 5 6 Poor or absent sense of smell 0

1 2 3 4 5 6 Foul or off taste or smell 0 1 2 3 4 5 6 Flu-like feeling 0 1 2 3 4 5 6

SINUS INFECTION FREQUENCY: Please estimate the average number of sinus infections that you have suffered <u>per year</u> during the past 5 years

None 1 2 3 4 5 6 7 8 9 10 More: _____

Comments: _____

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