**Nasal Obstruction Symptom Evaluation (NOSE)**

*Name: Date of Birth:*

*Date:*

Please help us to 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 very mild moderate fairly bad severe*

 *problem problem problem problem problem*

1. Nasal congestion 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 0 1 2 3 4

 nose during exercise or exertion

Please **mark a cross** on the lines below for each question.

How troublesome is your difficulty in breathing through your nose over all?

 *None Severe*

How troublesome is your difficulty in breathing for your right nostril?

 *None Severe*

How troublesome is your difficulty in breathing for your left nostril?

 *None Severe*