Patient Name

DOB:

MR #

**UW Health**
**(University of Wisconsin Hospitals and Clinics Authority)**

# NASAL OBSTRUCTIVE SYMPTOMS EVALUATION (NOSE) SCALE

Date: _____

Instructions: Please help us to better understand the impact of nasal obstruction on your quality of life by completing the following survey.

For patients with facial paralysis, please complete this form for nasal symptoms only on the side of the paralysis.

Over the past ONE MONTH, how much of a problem were the following conditions for you? Please circle 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 |

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