

		Never	Rarely	Less than half the time	Half the time or more	
81.	How often do your headaches interfere with your ability to work, study, or enjoy life?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
82.	How often do you have nausea with your headaches?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
83.	How often have you been unusually sensitive to light during your headaches?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Please respond to each question or statement by marking one box per row.						
During the past 7 days...		Not at all	A little bit	Somewhat	Quite a bit	Very much
84.	I feel fatigued.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
85.	I have trouble starting things because I am tired.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
86.	How run-down did you feel on average?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
87.	How fatigued were you on average?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
88.	How much were you bothered by your fatigue on average?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
89.	To what degree did your fatigue interfere with your physical functioning?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
90.	How often did you have to push yourself to get things done because of your fatigue?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
91.	How often did you have trouble finishing things because of your fatigue?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Please respond to the each question by marking one box per row.						
92.	What is your current marital status?	<input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced		<input type="checkbox"/> Widowed <input type="checkbox"/> Never Married <input type="checkbox"/> Living with Partner		
93.	What is the highest grade of school or highest degree you have completed?	<input type="checkbox"/> No Schooling <input type="checkbox"/> A few years <input type="checkbox"/> Finished grammar school <input type="checkbox"/> GED		<input type="checkbox"/> Some high school <input type="checkbox"/> High school graduate <input type="checkbox"/> Bachelor's degree	<input type="checkbox"/> Some college <input type="checkbox"/> Associate degree <input type="checkbox"/> Master's degree <input type="checkbox"/> Doctoral degree	
94.	About how much income did you receive last year before taxes and deductions?	<input type="checkbox"/> 0-9,999 <input type="checkbox"/> 10,000-24,999 <input type="checkbox"/> 25,000-49,999 <input type="checkbox"/> 50,000-74,999		<input type="checkbox"/> 75,000-99,999 <input type="checkbox"/> 100,000-149,999 <input type="checkbox"/> 150,000+		

Population Study of Nasal and Sinus Symptoms						
Please answer each question to the best of your ability. Please complete this survey in one sitting. It should take around 10 to 15 minutes to complete. Use a pen to answer your questions. Please return the survey using the included self-addressed stamped envelope. Thank you for your time!						
In your lifetime, have you ever had ...						
1.	Blockage of your nasal passages (nasal congestion) that lasted 3 months?	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
2.	Nasal discharge (runny nose) that was non-clear, green or yellow in color that lasted 3 months?	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
3.	Post-nasal drip (mucus dripping from the back of the nose into your throat) that lasted 3 months?	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
4.	Loss of sense of smell that lasted three months?	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
5.	Facial pain that lasted three months?	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
6.	Facial pressure that lasted three months?	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
<b>SKIP NOTICE:</b> If you answered "no" to all six questions above (questions #1-6), then skip to question #33.						
7.	My nasal and sinus symptoms are only a problem during some seasons.	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
8.	My nasal and sinus symptoms happen when I do NOT have a cold or flu.	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
9.	At what age did you start experiencing the nasal or sinus symptoms listed in questions 1 through 6 for more than 3 months at a time?	<input type="checkbox"/> 0-10 <input type="checkbox"/> 11-15 <input type="checkbox"/> 16-20 <input type="checkbox"/> 21-25	<input type="checkbox"/> 26-30 <input type="checkbox"/> 31-35 <input type="checkbox"/> 36-40 <input type="checkbox"/> 41-45	<input type="checkbox"/> 46-50 <input type="checkbox"/> 51-55 <input type="checkbox"/> 56-60 <input type="checkbox"/> Over 60		
The questions below are about breathing and nasal problems you may have had in the past 3 months.						
On average, how often in the past three months have you had ...		Never	Once in a while	Some of the time	Most of the time	All the time
10.	Blockage of your nasal passages (nasal congestion)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11.	Nasal discharge that was yellow or green in color?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12.	Post-nasal drip?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13.	Loss of sense of smell?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14.	Facial pain?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15.	Facial pressure?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>SKIP NOTICE:</b> If you answered "never" or "once in a while" to all six questions #10-15, then skip to question #33.						
Check the box that describes how often each problem below has happened in the past three months, on average.		Never	Once in a while	Some of the time	Most of the time	All the time
16.	Both of my nasal passages have blockage.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17.	At least one of my nasal passages is completely blocked.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18.	I have been very bothered by my blocked nasal passage(s).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19.	I have a lot of nasal discharge.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20.	I have to blow my nose more than 10 times a day because of my nasal discharge.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21.	I have been very bothered by my nasal discharge.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22.	I have been coughing after I eat or lie down	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
23.	I have had mucus in my throat that felt like a lump or blockage.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
24.	I have been very bothered by my post-nasal drip.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

In the past 3 months, on average...		Never	Once in a while	Some of the time	Most of the time	All the time
25.	I have not been able to smell anything.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
26.	I have been very bothered by my loss of sense of smell.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
27.	On a scale of 0 to 10, my facial pain has been at least a 5. (0 is no pain and 10 is worst possible pain.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
28.	I have been very bothered by my facial pain.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
29.	My facial pressure has been severe.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
30.	I have been very bothered by my facial pressure.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
31.	Where have you had facial pain in the past 3 months?	<input type="checkbox"/> Section 1 <input type="checkbox"/> Section 2 <input type="checkbox"/> Section 3 <input type="checkbox"/> Section 4 <input type="checkbox"/> I have not had facial pain				
32.	Where have you had facial pressure in the past 3 months?	<input type="checkbox"/> Section 1 <input type="checkbox"/> Section 2 <input type="checkbox"/> Section 3 <input type="checkbox"/> Section 4 <input type="checkbox"/> I have not had facial pain				
Check the box that describes how often, on average, you had the following problems in the past three months.						
SYMPTOM		Never	Once in a while	Some of the time	Most of the time	All the time
33.	Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
34.	Fevers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
35.	Coughing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
36.	Bad breath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
37.	Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
38.	Nasal Itching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
39.	Sneezing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
40.	Eye Itching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
41.	Eye tearing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
42.	Ear fullness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
43.	Ear pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
44.	Ear pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
45.	Wheezing (breathing with whistling sound in chest)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
46.	Chest tightness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
47.	Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
48.	Cold/ flu symptoms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Check "YES" next to medications you have taken for sinus problems over the past three months. Include medications your doctor prescribed and over the counter medications. If you have not taken medication for sinus problems, check "NO."						
49.	<b>Antibiotics</b> (Examples: Z-pack, Augmentin, Amoxicillin, Azithromycin, Doxycycline, Cipro, Levaquin)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
50.	<b>Steroid pills</b> (Examples: Prednisone, Medrol dose pack, Methylprednisolone)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
51.	<b>Nasal steroid sprays</b> (Examples: Nasonex, Mometasone, Flonase, Fluticasone)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
52.	<b>Antihistamine pills</b> (Examples: Allegra, Claritin, Clarinase, Zyrtec)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
53.	<b>Nasal antihistamines</b> (Examples: Astelin, Astepro, Azelastine, Patanase, Olopatidine)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
54.	<b>Decongestants</b> (Examples: Sudafed, Afrin)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please answer the questions below about sinus surgery.

55.	How many times have you had sinus surgery?	<input type="checkbox"/> 0 – <b>SKIP to question 57.</b> <input type="checkbox"/> 1	<input type="checkbox"/> 2 <input type="checkbox"/> 3 or more			
56.	Why did you have sinus surgery? (Check all that apply)	<input type="checkbox"/> Chronic rhinosinusitis <input type="checkbox"/> Other: _____	<input type="checkbox"/> Nasal polyps <input type="checkbox"/> Don't know			
Check "yes" if a doctor has <u>ever</u> told you that you have any of these health problems.						
57.	Migraines	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
58.	Sinus problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
59.	Nasal polyps	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
60.	Asthma that is made worse by aspirin (aspirin intolerant asthma)	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
61.	Hay fever (seasonal allergies)	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
62.	Lupus	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
63.	Rheumatoid arthritis	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
64.	Psoriasis	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
65.	Inflammatory bowel disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
66.	Chronic rhinosinusitis (CRS) <b>(If NO, SKIP to question #68)</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
67.	What test(s) did the doctor to do to test for CRS? (Check all that apply)	<input type="checkbox"/> CAT Scan <input type="checkbox"/> Endoscopy <input type="checkbox"/> MRI	<input type="checkbox"/> No test <input type="checkbox"/> Don't know			
Check "yes" if a doctor has <u>ever</u> told you that you have any of these health problems.						
68.	Nasal polyps <b>(If NO, SKIP to question #70)</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
69.	What test(s) did the doctor to do to test for nasal polyps? (Check all that apply)	<input type="checkbox"/> CAT Scan <input type="checkbox"/> Endoscopy <input type="checkbox"/> MRI	<input type="checkbox"/> No test <input type="checkbox"/> Don't know			
70.	Have you ever had a blood test or skin test for allergies? <b>(If NO, SKIP to question #72)</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
71.	Check the box next to the allergies that were found after a skin or blood test:	<input type="checkbox"/> Pollen <input type="checkbox"/> Pets <input type="checkbox"/> Mold <input type="checkbox"/> Other: _____	<input type="checkbox"/> Don't know <input type="checkbox"/> No allergies			
Place a check in the box that describes any wheezing or whistling in the chest you have experienced.						
Check the box that describes how often each problem below has happened in the <u>past twelve months</u> .		Never	Once in a while	Some of the time	Most of the time	All the time
72.	Wheezing, chest tightness, or whistling in the chest when you did not have a cold or the flu.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
73.	Woken at night due to wheezing.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
74.	Chest has sounded wheezy during or after exercise.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
75.	Dry cough at night, apart from a cough from a cold or chest infection.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Answer the following questions about asthma.						
76.	Have you ever been told by a doctor that you have asthma?	<input type="checkbox"/> Yes	<input type="checkbox"/> No – <b>SKIP to question #80</b>			
77.	Have you had your asthma symptoms in the last 12 months?	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
78.	How old were you when your asthma first began?	_____ years old				
79.	How old were you when you had your most recent asthma symptoms?	_____ years old				
Answer the following questions about headaches you have had in the past 12 months.						
80.	How often do you have headaches?	<input type="checkbox"/> Never <input type="checkbox"/> Once in a while <input type="checkbox"/> Some of the time	<input type="checkbox"/> Most of the time <input type="checkbox"/> All of the time			
<b>SKIP NOTICE:</b> If you checked "never" or "once in a while", skip to question #84.						