



Functional and Aesthetic Nasal Questionnaire

Section 1: Functional Nasal Assessment

Instructions: Please answer the following questions about your nasal function.

1. Do you have difficulty breathing through your nose?
☐ Yes ☐ No
2. Do you snore at night?
☐ Yes ☐ No
3. Do you breathe through your mouth during the day or night?
☐ Yes ☐ No
4. Do you find it difficult to breath while lying down?
☐ Yes ☐ No
5. Do you wake up at night due to breathing issues?
☐ Yes ☐ No
6. Do you experience daytime fatigue or sleepiness due to nasal obstruction?
☐ Yes ☐ No
7. If yes, does it interfere with your daily job function?
☐ Yes ☐ No
8. Do your breathing problems interfere with your activities like running, sport or other activities? ☐ Yes ☐ No
9. Do you experience sinus headaches?
☐ Yes ☐ No
If yes, how many times a month: _____
10. Do you use nasal sprays, humidifiers, or vaporizers?
☐ Yes ☐ No
If yes, please list: _____
11. Have you had previous nasal treatments (medical or surgical)?
☐ Yes ☐ No
If yes, please describe: _____

Section 2: SCHNOS Assessment

Instructions: Please rate the following statements from 0 (no concern) to 5 (severe concern).

SCHNOS-O (Functional Obstruction):

1. How difficult is it to breathe through your nose during exercise? 0–5: _____
2. How difficult is it to breathe through your nose during sleep? 0–5: _____
3. How often do you experience nasal congestion? 0–5: _____
4. How often do you experience nasal obstruction affecting daily activities? 0–5: _____
5. How often does nasal obstruction affect your sleep quality? 0–5: _____

Section 3: Additional Notes

- Please provide any other information about your nasal function or appearance that you feel is relevant:
