A. DANNY YAISH, D. O.
120 Park Avenue
Beaver Dam, WI 53916
920.885.5225

123 Hospital Drive, Suite 2003
Watertown, WI 53098
920.885.5225

BOARD CERTIFICATION
Otolaryngology
Facial Plastic Surgery
Sleep Medicine

Throat Irritation Questionnaire

Patient Name _____ Date:_____

Within the past month, how did the following problems affect you? Rank them from 0 (no problem) to 5 (severe problem).

1. Do you experience any problems with your voice or hoarseness?	0	1	2	3	4	5
2. Do you have problems with clearing your throat?	0	1	2	3	4	5
3. Do you have excess throat mucus or post nasal drip?	0	1	2	3	4	5
4. Do you have difficulty swallowing foods, liquids, or pills?	0	1	2	3	4	5
5. Do you have problems coughing after eating or after lying down?	0	1	2	3	4	5
6. Do you experience choking episodes or breathing difficulties?	0	1	2	3	4	5
7. Do you have problems with a troublesome or annoying cough?	0	1	2	3	4	5
8. Do you have sensations of something sticking in your throat or a lump in your throat?	0	1	2	3	4	5
9. Do you have problems with heartburn, chest pain, indigestion, or stomach acid coming up?	0	1	2	3	4	5

Total Score _____