

Office Use Only:

 In Office    Pre-Op or    Post-Op

Physician:

 Dr. Liberatore

## Totum ENT Sinus Outcome Report

Patient Name: \_\_\_\_\_ Pre-Op Date: \_\_\_\_\_ Post Op Date: \_\_\_\_\_

This questionnaire is intended to help define your symptoms and provide valuable information to our doctors. Please answer the following questions regarding any problems you have experienced over the past two weeks. Consider how severe the problem is, when you experience it and how frequently it happens, please rate each item below on how “bad” it is by circling the number that corresponds with how you feel.

SYMPTOMS	No Problem	Very Mild Problem	Mild or Slight Problem	Moderate Problem	Severe Problem	Problem As Bad As It Can Be
Runny Nose	0	1	2	3	4	5
Cough	0	1	2	3	4	5
Nasal Congestion	0	1	2	3	4	5
Post-nasal Discharge	0	1	2	3	4	5
Thick nasal Discharge	0	1	2	3	4	5
Loss of Smell	0	1	2	3	4	5
Difficulty Breathing	0	1	2	3	4	5
Recurring Sinus Infection	0	1	2	3	4	5
Suffer from Allergies	0	1	2	3	4	5
Ear Fullness / Popping	0	1	2	3	4	5
Dizziness	0	1	2	3	4	5
Ear Pain	0	1	2	3	4	5
Facial pain / Pressure	0	1	2	3	4	5
Headaches	0	1	2	3	4	5
Numbness to the Face	0	1	2	3	4	5
Snoring	0	1	2	3	4	5
Lack of Sleep	0	1	2	3	4	5
Fatigue	0	1	2	3	4	5
Reduced Productivity	0	1	2	3	4	5
Reduced Concentration	0	1	2	3	4	5



II. Xenobiotic Tolerability Test (XTT)	
<p>1. Are you presently using prescription drugs?  <input type="checkbox"/> Yes (1 pt.)                      If yes, how many are you currently taking? ____ (1 pt. each)  <input type="checkbox"/> No (0 pt.)</p>	<p>6. Do you commonly experience "brain fog," fatigue, or drowsiness?  <input type="checkbox"/> Yes (1 pt.) <input type="checkbox"/> No (0 pt.)</p>
<p>2. Are you presently taking one or more of the following over-the-counter drugs?  <input type="checkbox"/> Cimetidine (2 pts.) <input type="checkbox"/> Acetaminophen (2 pts.) <input type="checkbox"/> Estradiol (2 pts.)</p>	<p>7. Do you develop symptoms on exposure to fragrances, exhaust fumes, or strong odors?  <input type="checkbox"/> Yes (1 pt.) <input type="checkbox"/> No (0 pt.) <input type="checkbox"/> Don't know (0 pt.)</p>
<p>3. If you have used or currently use prescription drugs, which of the following scenarios best represents your response to them:  <input type="checkbox"/> Experience side effects, drug(s) is (are) efficacious at lowered dose(s) (3 pts.)  <input type="checkbox"/> Experience side effects, drug(s) is (are) efficacious at usual dose(s) (2 pts.)  <input type="checkbox"/> Experience no side effects, drug(s) is (are) usually not efficacious (2 pts.)  <input type="checkbox"/> Experience no side effects, drug(s) is (are) usually efficacious (0 pt.)</p>	<p>8. Do you feel ill after you consume even small amounts of alcohol?  <input type="checkbox"/> Yes (1 pt.) <input type="checkbox"/> No (0 pt.) <input type="checkbox"/> Don't know (0 pt.)</p>
<p>4. Do you currently use or within the last 6 months had you regularly used tobacco products?  <input type="checkbox"/> Yes (2 pts.) <input type="checkbox"/> No (0 pt.)</p>	<p>9. Do you have a personal history of:  <input type="checkbox"/> Environmental and/or chemical sensitivities (5 pts.)  <input type="checkbox"/> Chronic fatigue syndrome (5 pts.)  <input type="checkbox"/> Multiple chemical sensitivity (5 pts.)  <input type="checkbox"/> Fibromyalgia (3 pts.)  <input type="checkbox"/> Parkinson's type symptoms (3 pts.)  <input type="checkbox"/> Alcohol or chemical dependence (2 pts.)  <input type="checkbox"/> Asthma (1 pt.)</p>
<p>5. Do you have strong negative reactions to caffeine or caffeine containing products?  <input type="checkbox"/> Yes (1 pt.) <input type="checkbox"/> No (0 pt.) <input type="checkbox"/> Don't know (0 pt.)</p>	<p>10. Do you have a history of significant exposure to harmful chemicals such as herbicides, insecticides, pesticides, or organic solvents?  <input type="checkbox"/> Yes (1 pt.) <input type="checkbox"/> No (0 pt.)</p>
	<p>11. Do you have an adverse or allergic reaction when you consume sulfite containing foods such as wine, dried fruit, salad bar vegetables, etc?  <input type="checkbox"/> Yes (1 pt.) <input type="checkbox"/> No (0 pt.) <input type="checkbox"/> Don't know (0 pt.)</p>

Overall Score Tabulation						
Recommended protocols based on new detoxification questionnaire (MSQ and XTT)				MSQ SCORE _____ (High >50; moderate 15-49; Low <14)		
				XTT SCORE _____ (High >10; moderate 5-9; Low <4)		
MSQ Score	XTT Score	Description	Functional Medicine Protocol			
			Medical Food	Diet	Additional Nutraceutical Support	
50 or >	10 or >	High level of general symptoms and indicated symptoms of elevated toxic load	Medical food for imbalanced detoxifiers	28-day elimination diet	Bifunctional, antioxidant, and chlorophyllin nutraceuticals	
15-49	5-9	Moderate level of general symptoms with moderate symptoms of toxic load	Medical food for imbalanced detoxifiers	10-day elimination diet	Consider bifunctional, antioxidant, and chlorophyllin nutraceuticals	
14 or <	4 or <	Low level of general symptoms and minimal indicators of toxic load			Maintenance	
Recommended protocols based on new detoxification questionnaire (MSQ and XTT)				MSQ SCORE _____ (High >50; moderate 15-49; Low <14)		
				XTT SCORE _____ (High >10; moderate 5-9; Low <4)		
Additional Symptom-Specific Support						
Symptom			Nutraceutical Support			
Water retention and/or frequent or urgent urination			Kidney support nutraceuticals			
Heartburn and/or intestinal/stomach pain			Functional dyspepsia nutraceuticals			
Diarrhea, constipation, and/or intestinal/stomach pain			Probiotics			

Note: Patients with high MSQ but low XTT may be exhibiting pathology that is not related to toxic load. Other mechanisms should be considered such as inflammation/immune/allergic gastrointestinal dysfunction, oxidative stress, hormonal/neurotransmitter dysfunction, nutritional depletion, and/or mind body. Individualize support with specific medical foods, diet, and/or nutraceuticals.