UCSF Chronic Obstructive Sialadenitis Symptoms (COSS) Questionnaire

Today's Date ____________________ **Your Name** ________________________________

Circle Side and Gland Affected: 1. RIGHT or LEFT 2. PAROTID or SUBMANDIBULAR

Please read each question below carefully. To answer a question, select ONE of the numbers that is listed for that question, and draw a CIRCLE around it like this: (50%) or (5) .

Over the PAST MONTH...

1. What percentage of your time awake do you experience DISCOMFORT in the area of your salivery gland when NOT touching/pressing on the area?

Never ❯ 0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100% ❮ *Constantly*

2. How SEVERE is this discomfort?

No discomfort ❯ 0 1 2 3 4 5 6 7 8 9 10 ❮ *Very Severe*

3. What percentage of your time awake do you experience DISCOMFORT in the area of your salivary gland when touching/pressing on the area?

Never ❯ 0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100% ❮ *Constantly*

4. How SEVERE is this discomfort?

No discomfort ❯ 0 1 2 3 4 5 6 7 8 9 10 ❮ *Very Severe*

Over the PAST MONTH...

5. What percentage of the time do you experience SWELLING in the area of your salivary gland DURING MEALS?

Never ❯ 0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100% ❮ *Every meal*

6. How SEVERE is this swelling?

No swelling ❯ 0 1 2 3 4 5 6 7 8 9 10 ❮ *Very Severe*

7. What percentage of the time do you experience SWELLING in the area of your salivary gland IN BETWEEN MEALS?

Never ❯ 0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100% ❮ *Always*

8. How SEVERE is this swelling?

No swelling ❯ 0 1 2 3 4 5 6 7 8 9 10 ❮ *Very Severe*

9. Is this swelling noticeable by OTHERS?

Not at all ❯ 0 1 2 3 4 5 6 7 8 9 10 ❮ *Always*

10. Are you EMBARRASSED to be seen in public when your symptoms are active?

Not at all ❯ 0 1 2 3 4 5 6 7 8 9 10 ❮ *Always*

Please read each question below carefully. To answer a question, select ONE of the numbers that is listed for that question, and draw a CIRCLE around it like this: (50%) or (5) .

Over the PAST MONTH, what percentage of the time do you experience:	*Never*										*Constantly*
11. Too **LITTLE** saliva (dry mouth)?	0%	10	20	30	40	50	60	70	80	90	100%
12. Too **MUCH** saliva?	0%	10	20	30	40	50	60	70	80	90	100%
13. A **foul taste** in your mouth?	0%	10	20	30	40	50	60	70	80	90	100%

Over the PAST MONTH, how much do your symptoms affect your ability to:	*Not at all*										*Very severely*
14. Swallow?	0	10	20	30	40	50	60	70	80	90	100
15. Speak?	0	10	20	30	40	50	60	70	80	90	100
16. Chew?	0	10	20	30	40	50	60	70	80	90	100

Over the PAST MONTH, how much do your symptoms interfere with your:	*Not at all*										*Very severely*
17. Diet?	0	10	20	30	40	50	60	70	80	90	100
18. Sleep?	0	10	20	30	40	50	60	70	80	90	100
19. Daily activities?	0	10	20	30	40	50	60	70	80	90	100
20. Quality of life?	0	10	20	30	40	50	60	70	80	90	100