Is It Nasal Allergy? Find Out For Sure

Allergy & Asthma NETWORK

Complete the **Rhinitis Control Assessment Test (RCAT)** below and discuss the results with your healthcare provider.

NAME: _____ DATE OF BIRTH: / /

Choose the response that best describes your nasal and other allergy symptoms that are not related to a cold or the flu.

1. During the past week, how often did you have nasal congestion?	❍ 5. Never	❍ 4. Rarely	❍ 3. Sometimes	❍ 2. Often	❍ 1. Extremely Often
2. During the past week, how often did you sneeze?	❍ 5. Never	❍ 4. Rarely	❍ 3. Sometimes	❍ 2. Often	❍ 1. Extremely Often
3. During the past week, how often did you have watery eyes?	❍ 5. Never	❍ 4. Rarely	❍ 3. Sometimes	❍ 2. Often	❍ 1. Extremely Often
4. During the past week, to what extent did your nasal or other allergy symptoms interfere with your sleep?	❍ 5. Not at All	❍ 4. A Little	❍ 3. Somewhat	❍ 2. A Lot	❍ 1. All the Time
5. During the past week, how often did you avoid any activities (for example, visiting a house with a dog or cat, gardening) because of your nasal or other allergy symptoms?	❍ 5. Never	❍ 4. Rarely	❍ 3. Sometimes	❍ 2. Often	❍ 1. Extremely Often
6. During the past week, how well were your nasal or other allergy symptoms controlled?	❍ 5. Completely	❍ 4. Very	❍ 3. Somewhat	❍ 2. A Little	❍ 1. Not at All

Add your responses and enter your TOTAL HERE: ☐ If your score is 21 or less, share your results with your healthcare provider.

Please answer the additional questions below and discuss the results with your healthcare provider.

Over the past 3 months, which medications have you used to treat your allergy symptoms? (Check all that apply)

Over-the-counter	Prescription	
❍	❍	Oral Tablets/Pills
❍	❍	Oral Tablets/Pills with a "D"
❍	❍	Nasal Sprays
❍	❍	Eye Drops
❍	❍	Other _____

If you took medication in the past 3 months for your allergies, were your allergy symptoms relieved to your satisfaction?

❍ Yes ❍ No

If "no," what medications were you taking?
(Please list all, including any over-the-counter medications and/or natural remedies)

_____

_____

_____

_____

Which medication(s) are you currently taking to help relieve your allergy symptoms? (Please list all, including any over-the-counter medications and/or natural remedies)

_____

_____

_____

How satisfied are you with your current treatment? (Check one)

❍ Very satisfied, I feel fine ❍ I'm not satisfied, I don't feel any different ❍ Somewhat satisfied, I feel okay ❍ I feel really awful

Please list all medications you are taking, including prescription or over-the-counter medicines, herbal treatments, vitamins and supplements: _____

_____

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