Is It Nasal Allergy? Find Out For Sure

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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