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.

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<td>1. During the past week, how often did you have nasal congestion?</td>
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<td>2. During the past week, how often did you sneeze?</td>
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<td>3. During the past week, how often did you have watery eyes?</td>
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<td>4. During the past week, to what extent did your nasal or other allergy symptoms interfere with your sleep?</td>
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<td>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?</td>
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<td>6. During the past week, how well were your nasal or other allergy symptoms controlled?</td>
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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)*

- 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: ___

____________________________________________________________________

_______________________________________________________________