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?

2. During the past week, how often did you sneeze?

3. During the past week, how often did you have watery eyes?

4. During the past week, to what extent did your nasal or other allergy symptoms interfere with your sleep?

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?

6. During the past week, how well were your nasal or other allergy symptoms controlled?

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: ____________________________

__________________________________________________________

__________________________________________________________

__________________________________________________________

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