

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?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	5. Never	4. Rarely	3. Sometimes	2. Often	1. Extremely Often
2. During the past week, how often did you sneeze?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	5. Never	4. Rarely	3. Sometimes	2. Often	1. Extremely Often
3. During the past week, how often did you have watery eyes?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	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?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	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?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	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?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	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

<input type="radio"/>	<input type="radio"/>	Oral Tablets/Pills
<input type="radio"/>	<input type="radio"/>	Oral Tablets/Pills with a "D"
<input type="radio"/>	<input type="radio"/>	Nasal Sprays
<input type="radio"/>	<input type="radio"/>	Eye Drops
<input type="radio"/>	<input type="radio"/>	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: _____