Could you have Allergic Rhinitis?

Please
1. Fill in the details on the right.
2. Answer Questions 1-4 by ticking the box next to your answer.
3. Do not leave any questions unanswered.
4. Follow the instructions for Question 5.
5. Return you completed form to your doctor/nurse

First name: ____________________________
Last name: ____________________________
Date: ________________________________

1. Do you have any of the following symptoms or have a history of suffering from any of them?
   a. Watery runny nose  □ Yes □ No
   b. Sneezing (especially violent and in bouts)  □ Yes □ No
   c. Nasal obstruction (feeling of being unable to breathe through your nose)  □ Yes □ No
   d. Itchy nose  □ Yes □ No
   e. Watery, red itchy eyes  □ Yes □ No

2. What causes your symptoms?
   a. Pollen from trees, flowers and grasses  □ Yes □ No
   b. Mould (both indoors and outdoors)  □ Yes □ No
   c. Furred animals (especially cats, dogs and mice)  □ Yes □ No
   d. Dusty places  □ Yes □ No

3. How long do your symptoms last?
   a. More than four days a week  □ Yes □ No
   b. More than four weeks in a row  □ Yes □ No

4. How do the symptoms affect you?
   a. Symptoms disturb your sleep  □ Yes □ No
   b. Symptoms restrict your daily activities (sports, leisure, etc)  □ Yes □ No
   c. Symptoms restrict your participation in school or work  □ Yes □ No
   d. Symptoms are troublesome to you  □ Yes □ No

5. How much do your symptoms bother you?
   Not at all 10  Very much

Please mark the line above with an X to show how much your nose or eye symptoms bother you. For example: