ALLERGIC RHINITIS QUESTIONNAIRE

PATIENT NAME _____ DATE_____

1. Do you have any of the following symptoms?

   Chronic nasal congestion or chronic stuffy nose? ☐**YES** ☐**NO**

   Frequent runny nose and/or postnasal drip (down the back of your throat)? ☐**YES** ☐**NO**

   Frequent red, itchy eyes? ☐**YES** ☐**NO**

   Loss of smell? ☐**YES** ☐**NO**

   Headaches or facial pain? ☐**YES** ☐**NO**

   Recurrent nosebleeds? ☐**YES** ☐**NO**

2. Are your symptoms year-round? ☐**YES** ☐**NO**

   Are your symptoms only seasonal or only at certain times of the year? ☐**YES** ☐**NO**

   In which season are your symptoms the worst? ☐**SPRING** ☐**SUMMER** ☐**FALL** ☐**WINTER**

3. Do your symptoms cause any of the following?

   Disruptions in school or work? ☐**YES** ☐**NO**

   Problems sleeping? ☐**YES** ☐**NO**

   Problems exercising or doing other activities? ☐**YES** ☐**NO**

4. What triggers your symptoms?

   Pollen from trees, grasses, and/or flowers? ☐**YES** ☐**NO**

   Exposure to cats? ☐**YES** ☐**NO**

   Exposure to dogs? ☐**YES** ☐**NO**

   Exposure to tobacco smoke? ☐**YES** ☐**NO**

5. Have you ever used a nose spray for your symptoms? ☐**YES** ☐**NO**

   If yes, which one(s)? ☐**Flonase** ☐ **Nasonex** ☐**Veramyst** ☐**Omnaris** ☐**Astelin** ☐**Patanase**

   Which medication, if any, improved your symptoms?_____

6. Have you ever used an antihistamine/allergy medication for your symptoms? ☐**YES** ☐**NO**

7. If yes, which one(s)? ☐**Benadryl** ☐ **Claritin** ☐**Zyrtec** ☐**Allegra** ☐**Singulair** ☐ **Atarax**
Which medication, if any, improved your symptoms?_____