Name _____

Age _____ Date _____

Patient Survey RHINITIS

Before you started your current allergy treatment, how bad were these symptoms when your allergies were most active?

	No problem	Minimal problem	Mild problem	Moderate problem	Severe problem	Very severe problem
Fatigue	0	1	2	3	4	5
Trouble sleeping	0	1	2	3	4	5
Irritability	0	1	2	3	4	5
Dizziness	0	1	2	3	4	5
Post-nasal drip	0	1	2	3	4	5
Sore throat	0	1	2	3	4	5
Sinus headache/pressure	0	1	2	3	4	5
Sneezing	0	1	2	3	4	5
Nasal itching	0	1	2	3	4	5
Nasal blockage	0	1	2	3	4	5
Nasal green/yellow mucus	0	1	2	3	4	5
Clear watery mucus	0	1	2	3	4	5
Loss of sense of smell	0	1	2	3	4	5
Snoring	0	1	2	3	4	5
Earache	0	1	2	3	4	5
Eye itching	0	1	2	3	4	5
Eye redness	0	1	2	3	4	5
Eye watering	0	1	2	3	4	5
Eye burning	0	1	2	3	4	5
Shortness of breath	0	1	2	3	4	5
Coughing	0	1	2	3	4	5
Wheezing	0	1	2	3	4	5
Chest tightness	0	1	2	3	4	5
Chest pain	0	1	2	3	4	5
Phlegm	0	1	2	3	4	5

In the year before you started your current allergy treatment in this office, how many times did the following happen?

You missed work or school due to allergies, asthma, sinusitis, etc. _____

You went to the emergency room for an allergy-related problem _____

You were hospitalized for an allergy-related problem _____

You had nose, ear or sinus surgery, including tube placement _____

You used antibiotics for sinus, chest or ear infections _____

In the year **before** you started your current treatment, how many different **daily** medications, including nasal sprays, inhalers, eye drops and pills, were you taking?

_____