Control of Allergic Rhinitis and Asthma Test

Please mark with an (☒).

Because of your allergic respiratory illness (asthma, rhinitis, allergies), on average during the last 4 weeks, **how many times have you had**:

	Never	Up to 2 days per week	More than 2 days per week	Almost every day
1. Stuffy nose?	☐ 3	☐ 2	☐ 1	☐ 0
2. Sneezing?	☐ 3	☐ 2	☐ 1	☐ 0
3. Itchy nose?	☐ 3	☐ 2	☐ 1	☐ 0
4. Runny nose?	☐ 3	☐ 2	☐ 1	☐ 0
5. Shortness of breath/dyspnea?	☐ 3	☐ 2	☐ 1	☐ 0
6. High pitch sound in chest/ wheezing?	☐ 3	☐ 2	☐ 1	☐ 0
7. Chest tightness during exercise?	☐ 3	☐ 2	☐ 1	☐ 0
8. Tiredness/ difficulty doing day to day or chores?	☐ 3	☐ 2	☐ 1	☐ 0
9. Woke up in the middle of the night?	☐ 3	☐ 2	☐ 1	☐ 0

In the last four weeks how many times have you:	I'm not taking any medications	Never	Less than 7 days	7 or more days
1. increased the use of your medicine because of your allergic respiratory diseases (asthma, rhinitis, allergies)?	☐ 3	☐ 3	☐ 2	☐ 0

_____ *Points*

(result of addition of the 10 questions; worst 0, best 30)

Date __ / __ / ____