Control of Allergic Rhinitis and Asthma Test

Please mark the following boxes with a cross (☒).

Due to your allergic respiratory diseases (asthma, rhinitis, allergies) in the last four weeks, on average, **how many times did you have**:

	Never	Up to2 days per week	More than 2 days per week	Almost every day or every day
1. Blocked 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/dyspnoea?	☐ 3	☐ 2	☐ 1	☐ 0
6. Wheezing in the chest?	☐ 3	☐ 2	☐ 1	☐ 0
7. Chest tightness upon physical exercise?	☐ 3	☐ 2	☐ 1	☐ 0
8. Tiredness/ limitations in doing daily tasks?	☐ 3	☐ 2	☐ 1	☐ 0
9. Woke up during the night?	☐ 3	☐ 2	☐ 1	☐ 0

In the last 4 weeks, how many times did you:	I'm not taking any medicines	Never	Less than 7 days	7 or more days
1. increased the use (dosage or frequency) of your medicines because of your allergic respiratory diseases (asthma, rhinitis, allergies)?	☐ 3	☐ 3	☐ 2	☐ 0

_____ *Score*

(Sum of all 10 questions, 0 - worst, best - 30)

Date __ /__ /____