



# 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?	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0
2. Sneezing?	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0
3. Itchy nose?	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0
4. Runny nose?	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0
5. Shortness of breath/dyspnea?	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0
6. High pitch sound in chest/ wheezing?	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0
7. Chest tightness during exercise?	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0
8. Tiredness/ difficulty doing day to day or chores?	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0
9. Woke up in the middle of the night?	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0

In the last <u>four weeks</u> 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)?	<input type="checkbox"/> 3	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 0

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

Date \_\_ / \_\_ / \_\_