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Allergy Re-Evaluation Questionnaire

Name: _____

Date: ____/____/____

Please answer every question by circling the appropriate number or letter. If you are unsure about how to answer a question, give the best answer you can.

1. In the past 4 weeks, how often have you been bothered by your allergy symptoms?

- a. None of the time b. A little of the time c. Some of the time
d. Most of the time e. All of the time

2. Overall, how would you now rate your allergy symptoms?

- a. None b. Very Mild c. Mild d. Moderate e. Severe f. Very Severe

3. Compared to one year ago, how would you now rate your allergy symptoms in general?

- a. Much Better b. Somewhat Better c. About the same
d. Somewhat Worse e. Much Worse

4. During the last 4 weeks, on average how many days per week, did you need to use allergy medications (any)?

- a. Not at all b. 1 or 2 days c. 3 or 4 days d. 5 or 6 days e. Every day

During the past 4 weeks, how many weeks have you taken: (Circle one answer in each row)

5. Allergy medications (pill form) purchased "over the counter": (without a prescription)

- a. 0 weeks b. 1 week c. 2 weeks d. 3 weeks e. 4 weeks

6. Allergy medication (pill form) Prescribed by your doctor:

- a. 0 weeks b. 1 weeks c. 2 weeks d. 3 weeks e. 4 weeks

During the past 8 weeks, how many weeks have you taken: (Circle one)

7. Nasal sprays prescribed by your doctor:

- a. 0 weeks b. 1 week c. 2 weeks d. 3 weeks e. 4 weeks

8. Do you have an updated epinephrine-pen at home? YES NO

Please list below all medications that you take, including non-prescription medication, and their dose.
