

RHINITIS CONTROL ASSESSMENT TEST (RCAT)

PATIENT NAME: _____

DATE COMPLETED: _____

PLEASE CHECK THE CATEGORY THAT BEST ANSWERS THE QUESTION.

Write the score for each item in the column to the right.

1. During the past WEEK, how often did you have nasal congestion?

Never	Rarely	Sometimes	Often	Extremely Often	SCORE
5 <input type="checkbox"/>	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	

2. During the past WEEK, how often did you sneeze?

Never	Rarely	Sometimes	Often	Extremely Often	SCORE
5 <input type="checkbox"/>	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	

3. During the past WEEK, how often did you have watery eyes?

Never	Rarely	Sometimes	Often	Extremely Often	SCORE
5 <input type="checkbox"/>	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	

4. During the past WEEK, to what extent did your nasal or other allergy symptoms interfere with your sleep?

Never	Rarely	Sometimes	Often	Extremely Often	SCORE
5 <input type="checkbox"/>	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	

5. During the past WEEK, how often did you AVOID any activity (for example, gardening, exercising, visiting a house with a dog or cat) because of your nasal or other allergy symptoms?

Never	Rarely	Sometimes	Often	Extremely Often	SCORE
5 <input type="checkbox"/>	4 <input type="checkbox"/>	3 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	
					TOTAL SCORE

The higher the score, the better controlled you are with your nose and eye symptoms.

A score that is **lower** than **21** suggest that you are not well-controlled.