Hay fever and nose symptoms questionnaire

For sneezing, runny or blocked nose, itchy eyes or sinus symptoms.

Please type your answers into this form (or print and fill it in), save it, and email it to **referrals@vidamedical.com.au** at least **7 days before your appointment**. Skip anything that doesn't apply. If you are completing this for a child, answer for the child.

About you

Full name

Date of birth

Today's date

Phone and email

Completed by (if not the patient)

Usual GP and clinic

Your symptoms

Which symptoms do you have?

- ☐ Sneezing
- ☐ Runny nose
- ☐ Blocked nose
- ☐ Itchy nose or throat
- ☐ Itchy, watery eyes
- ☐ Snoring or mouth breathing
- ☐ Reduced sense of smell
- ☐ Facial pressure or headache
- ☐ Post-nasal drip

How long have you had these symptoms?

When are you worst?

- ☐ Spring
- ☐ Summer
- ☐ Autumn
- ☐ Winter
- ☐ All year round
- ☐ Thunderstorm asthma in the past

What sets it off?

- ☐ Grass or being outdoors
- ☐ Dust or vacuuming
- ☐ Cats
- ☐ Dogs
- ☐ Horses or other animals
- ☐ Mould or damp
- ☐ Something at work
- ☐ Smoke or perfume
- ☐ Not sure

Nasal symptom score (TNSS)

Total Nasal Symptom Score. Tick one box per symptom for how it has been over the past week. 0 = none, 1 = mild (present but easily tolerated), 2 = moderate (bothersome but tolerable), 3 = severe (hard to tolerate, interferes with sleep or daily activities).

Symptom	0 None	1 Mild	2 Moderate	3 Severe
Blocked or stuffy nose	☐	☐	☐	☐
Runny nose	☐	☐	☐	☐
Sneezing	☐	☐	☐	☐
Itchy nose	☐	☐	☐	☐

Clinic use: TNSS total (out of 12)

How much it bothers you (ARIA scale)

Overall, how much are your allergy symptoms bothering you today?

Not at all ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 Extremely

How much do they affect your sleep?

Not at all ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 Extremely

How much do they affect work, study or daily activities?

Not at all ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 Extremely

Treatments tried

Treatment	Used? (Y/N)	How long?	Did it help?
Antihistamine tablets			
Steroid nasal spray			
Combination nasal spray			
Eye drops			
Saline rinses			
Other			

Your home and lifestyle

Pets at home

Do you smoke or vape, or live with someone who does? ☐ Yes ☐ No ☐ Unsure

Do you also have asthma or wheeze? ☐ Yes ☐ No ☐ Unsure

Are you interested in immunotherapy (desensitisation)? ☐ Yes ☐ No ☐ Unsure

Medicines

All medicines you take, including sprays, creams, vitamins and supplements

Do you take any of these?

☐ Antihistamines (e.g. Telfast, Zyrtec, Claratyne)
☐ Blood pressure or heart medicines
☐ Regular ibuprofen or aspirin
☐ Adrenaline autoinjector (EpiPen / Anapen)

Autoinjector expiry date (if you have one)

Family history

Does a parent, brother or sister have:

☐ Food allergy ☐ Eczema ☐ Asthma
☐ Hay fever ☐ Hives ☐ Not sure

Your goals

What would you most like to get out of this appointment?

Previous allergy tests (type, date, result). Please bring copies if available.

Before you arrive

Medicines: antihistamines and some other medicines can affect allergy testing. We'll email you instructions on which to pause and when. **Keep taking your asthma medicines.**

Bring: previous test results, photos of any reactions, and your adrenaline autoinjector if you have one.

Your information is confidential and stored in your medical record in line with our privacy policy.