ALLERGY QUALITY OF LIFE QUESTIONNAIRE

PATIENT NAME: _____ **D.O.B.** ____/____/_____ **Today's Date:** ____/____/_____

OFFICE USE ONLY **Baseline QLQ:** _____ **6 Month QLQ:** _____ **12 Month QLQ:** _____

The following 16 subject symptoms and lifestyle questions are used to assess your allergy symptoms and the impact they have on your quality of life. Each one is based on a 1 to 10 scale; where 1 has very little impact while 10 equates to a severe impact that allergies have on your overall quality of life. Please rate the following:

		< MILD >			< MODERATE >					< SEVERE >
1.	Watery-Itchy/ Burning Eyes	1	2	3	4	5	6	7	8	9	10
2.	Ear Infections/ Discharge	1	2	3	4	5	6	7	8	9	10
3.	Sinus Drainage/ Stuffiness	1	2	3	4	5	6	7	8	9	10
4.	Sinus Infections	1	2	3	4	5	6	7	8	9	10
5.	Throat Tenderness	1	2	3	4	5	6	7	8	9	10
6.	Coughing/ Sneezing	1	2	3	4	5	6	7	8	9	10
7.	Headache/ Migraine	1	2	3	4	5	6	7	8	9	10
8.	Rash/ Dermatitis	1	2	3	4	5	6	7	8	9	10
9.	Respiratory Infections	1	2	3	4	5	6	7	8	9	10
10.	Sleep Disturbance	1	2	3	4	5	6	7	8	9	10

11. Please rate your overall medication use (Over the Counter/ Prescription) to control your allergy symptoms?

1 2 3 4 5 6 7 8 9 10

12. In the past month rate the impact your allergies have had on social events or hobbies.

1 2 3 4 5 6 7 8 9 10

13. In the past month rate the impact your allergies have had on your employment or school.

1 2 3 4 5 6 7 8 9 10

14. In the past month rate the overall allergy symptoms you have experienced when you are around or in contact with animals?

1 2 3 4 5 6 7 8 9 10

15. In the past month how would you rate your overall allergy symptoms when exposed to the outdoors?

1 2 3 4 5 6 7 8 9 10

16. In the past month how would your rate your overall allergy symptoms when at home or when performing household work?

1 2 3 4 5 6 7 8 9 10

THANK YOU