



HOW TO PREPARE FOR YOUR FOLLOW-UP CONSULTATION

If you are experiencing symptoms of allergic rhinitis and a trial of self-management, supported with pharmacy care, has not helped, it is time to visit your family doctor/general practitioner. They can help determine the correct diagnosis and create a treatment plan that fits your needs. Use our 'Prepare for your first consultation' guide to prepare for your first doctor's visit.

This guide is designed to help you prepare for your follow-up appointment now that you've been diagnosed with allergic rhinitis—whether that appointment is with your GP to review your treatment, or with a specialist after you've been referred.

It guide will help you think about how you're feeling, what topics or concerns you would like to talk about during your visit, and how your current allergic rhinitis treatment is going — including what is working well and any side effects you might be noticing.



With this preparation, you'll feel more confident, make the most of your time with your healthcare provider, and take an active role in managing your health.





BEFORE your follow-up consultation

1 Information about your lifestyle

Understanding your lifestyle is crucial in identifying potential causes of your symptoms. Please circle the answer that best reflects your lifestyle.

Do you smoke/vape? Yes – Formerly – Never

Do you drink alcohol on a daily basis? Yes - No

Do you use recreational drugs? Yes - No

Do you have pets? Yes – No

What do you do for work? _____

What are your hobbies? _____

2 Exploration allergy history

To help us understand your allergy risk, please indicate whether **anyone in your biological family** is known to have:

- Food allergy**
- Eczema (atopic dermatitis)**
- Hay fever (allergic rhinitis)**
- Asthma**

As an **infant/child/adolescent**, were you **affected by**:

- Food allergy**
- Eczema (atopic dermatitis)**
- Hay fever (allergic rhinitis)**
- Asthma**



BEFORE your follow-up consultation

1 How have I been feeling?

On a scale of 0 to 10, please indicate with a vertical line how bothersome your nasal/eye symptoms have been in the past week:

Example:



Your evaluation:



Your doctor may ask you to fill out additional questionnaires before your appointment to evaluate how your symptoms have evolved with your current treatment.

Symptom

How difficult has it been over the past week?

(please make a cross over the number that better rates your symptoms)



Nasal congestion

0

1

2

3



Runny nose

0

1

2

3



Sneezing

0

1

2

3



Nasal itch

0

1

2

3



Watery eyes

0

1

2

3



Itchy ears and/or palate

0

1

2

3

0 No symptoms

1 MILD (symptoms present but easily tolerated)

2 MODERATE (symptoms present and bothersome, but tolerable)

3 SEVERE (symptoms present and interfering with activities of daily living and/or sleep)



BEFORE your follow-up consultation

Which triggers seem to make your symptoms worse?

Below is a list of potential triggers that make your symptoms worse. Please check all relevant boxes.

- Cigarette smoke/vaping/wood-burning smoke
- Strong odors, dust, chemicals or fumes (at home or work)
- During exercise
- Respiratory infections (colds, the flu, COVID-19, ...)
- Weather changes/extreme temperatures (hot or cold)/windy or stormy weather
- Severe air pollution**
- Exposure to pollen or other allergens (animals/mould/...)
- Stress/strong emotions
- When eating specific foods
- When taking certain medications
- When drinking alcoholic beverages
- When exposed to: _____
- Other trigger(s): _____

Other symptoms

Check the box if you have any of the following symptoms:



Headache, Facial pain/pressure



Loss of smell



Mucus dripping into the back of the throat



Snoring



Eczema



Chest tightness



Wheezing



Shortness of breath



Long-term cough



Ear ache or reduced hearing



Swelling in the mouth



Tiredness



Gut pains



Rash



Feeling ill

Other?



BEFORE your follow-up consultation

5 My medical history

Please indicate any medical conditions that apply to you by ticking the appropriate boxes below. This includes any current conditions or those you have experienced in the past.

Airway diseases (chronic rhinosinusitis, nasal polyp syndrome, pneumonia, chronic bronchitis, emphysema, chronic cough, use of a C-PAP machine...)	<input type="checkbox"/>
Cardiovascular disease (high blood pressure, high cholesterol, heart arrhythmia, heart failure...)	<input type="checkbox"/>
Musculoskeletal disorders (osteoporosis, osteoarthritis, ...)	<input type="checkbox"/>
Hormonal disorders (diabetes, thyroid disorders, adrenal problems)	<input type="checkbox"/>
Gastrointestinal disease (gastroesophageal reflux, gastric ulcers, hepatitis)	<input type="checkbox"/>
Skin disease (atopic dermatitis/eczema, urticaria, psoriasis)	<input type="checkbox"/>
Kidney disease (renal insufficiency, chronic kidney disease)	<input type="checkbox"/>
Eye disease (cataract, glaucoma, allergic conjunctivitis, dry eye syndrome)	<input type="checkbox"/>
Neurological disorders (epilepsy, migraine, stroke, multiple sclerosis)	<input type="checkbox"/>
Mental health conditions (anxiety disorder, depression, addiction)	<input type="checkbox"/>
Cancer or tumours (benign, malignant or unknown)	<input type="checkbox"/>
Auto-immune disorders (lupus, sarcoidosis, Crohn's disease, granulomatosis with polyangiitis/GPA (formerly Wegener's granulomatosis), rheumatoid arthritis, Sjogren's syndrome, eosinophilic granulomatosis with polyangiitis (EGPA; formerly Churg–Strauss), ...)	<input type="checkbox"/>
Other disease(s):	<input type="checkbox"/>



BEFORE your follow-up consultation

3 My medication overview

Please list all the medications and supplements you are currently using. This includes not only tablets but also inhalers and liquids such as nasal sprays, syrups, eye drops, and topical treatments (creams, ointments), as well as any other forms of medication. Be sure to include **both prescription medications and any over-the-counter treatments** (those you buy without a prescription).

If you observe symptoms after taking a specific medication, please do not forget to note this in your medication diary.

Example:

Medication name	Reason	Dose unit	When, how much I take
Paracetamol	Pain management	1g	Max. 3 times per day 1 tablet
Hydrocortisone cream	Eczema	1% w/w	Once a day 1 fingertip

Medication name	Reason	Dose unit	When and how much I take



4 Experience with my first treatment

1. Name of the medication:

My experience

Positive:

Negative (side effects/unexpected effects):

Are you encountering any practical difficulties with your treatment, such as how to use it, how often to take it, when to take it, or remembering to take it? Is there anything in your treatment plan that you find confusing?

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2. Name of the medication:

My experience

Positive:

Negative (side effects/unexpected effects):

Are you encountering any practical difficulties with your treatment, such as how to use it, how often to take it, when to take it, or remembering to take it? Is there anything in your treatment plan that you find confusing?

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6 Thought prompts

Below is a detailed list of thought prompts designed to guide a thorough and productive conversation with your treating physician:

- **New treatment:**
 - How will this treatment be different from my previous one? What are the expected benefits and downsides?
- **Alternative treatment options:**
 - Are there other treatment options available? What are the pros and cons?
 - Would surgery or allergen immunotherapy be an option for me? Why (not)?
 - What are the risks of not starting this treatment now?
- **Additional tests or investigations:**
 - Why are these tests necessary? What will we learn from it? What happens if I don't get this test?
 - What are the costs, benefits and potential downsides?
 - What is likely to happen next, after I have the test?
- **Progress monitoring:**
 - How will we know if this treatment is working for me? What symptoms or changes should I watch for?
- **Written resources:**
 - Are there any resources that you could recommend to me (websites or apps) to learn more about my condition or treatment?
- **Impact on daily life:**
 - Will the current/newly proposed treatment affect my daily activities, work or lifestyle?
- **Duration of treatment:**
 - How long will I need to continue this treatment?
 - Will the dosage or the way I take my treatment change over time?
- **Medication interactions:**
 - Is the proposed treatment safe to use with my other medications or supplements?
 - Am I allowed to drink alcohol while using this newly suggested treatment?
- **Follow-up plan:**
 - When should I schedule a follow-up appointment?
 - What should I do if my symptoms get worse or if I do not notice a significant improvement?
- **Long-term lookout:**
 - Is there a chance that my condition might lead to long-term effects or complications?
 - Will my treatment cure my condition or just manage the symptoms?

Notes:

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DURING your consultation

1 Tips/tricks and information provided by my doctor

Taking notes during your consultation can be very helpful, especially since it can feel overwhelming to get a lot of information at once. You can even ask your doctor to help you write down the key points so you don't forget them. This might include important details about your health or condition, tips to manage it, and advice on how to use your treatment properly.

General information

Tips/tricks to help improve my condition:

Advice on how to use or take my medication/treatment correctly:



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