**Patient Survey**

.

1. How old are you?
2. Please indicate your gender:
	* Female
	* Male
	* Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. How long have you had seasonal allergy symptoms?
	* Less than a year
	* Between 1 and 5 years
	* Between 6 and 10 years
	* More than 10 years
4. How often do you see an allergist for your seasonal allergies?
	* This is my first appointment with an allergist
	* This is a regular follow-up appointment for my seasonal allergies that occurs every \_\_\_\_ months
	* I see my allergist when my allergies are bothering me, approximately every \_\_\_\_ \_\_\_
5. For this question, think about allergy season, when your symptoms are at their worst. Mark on a scale of 0 to 5 how these seasonal allergy symptoms affect you (0 = not at all bothersome, 10 = very bothersome):
* Runny nose

0-----------------------------------------------------------5--------------------------------------------------10

* Sneezing

0-----------------------------------------------------------5--------------------------------------------------10

* Blocked nose

0-----------------------------------------------------------5--------------------------------------------------10

* Nasal itch

0-----------------------------------------------------------5--------------------------------------------------10

* Watery eyes

0-----------------------------------------------------------5--------------------------------------------------10

* Red or itchy eyes

0-----------------------------------------------------------5--------------------------------------------------10

* Itchy throat or palate

0-----------------------------------------------------------5--------------------------------------------------10

* Headaches

0-----------------------------------------------------------5--------------------------------------------------10

* How long you sleep

0-----------------------------------------------------------5--------------------------------------------------10

* How well you sleep

0-----------------------------------------------------------5--------------------------------------------------10

1. During peak allergy season, how much do your allergies affect you? Rank using the following scale:
	* + No effect
		+ 1 day per week affected
		+ 2-3 days per week affected
		+ 4-5 days per week affected
		+ 6-7 days per week affected

Please check the box that applies for each question

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| How much do your allergies affect your? | No effect | 1 day per week affected | 2-3 days per week affected | 4-5 days per week affected | 6-7 days per week affected |
| Regular day to day life? |  |  |  |  |  |
| How long you sleep? |  |  |  |  |  |
| How well you sleep? |  |  |  |  |  |
| Social activities or sports? |  |  |  |  |  |
| Performance at work or school? |  |  |  |  |  |
| Attendance at work or school? |  |  |  |  |  |

1. Overall, during peak allergy season, how much do your allergies bother you in your daily life?
* Not at all
* A little
* Somewhat
* A lot

For the next questions, please read the pamphlet on allergy immunotherapy before answering.

1. Before reading the pamphlet, had you ever heard about allergy immunotherapy?
	* Yes
	* No
2. If you answered “yes”, where did you hear about allergy immunotherapy?
* My allergist
* My family doctor
* Family member or friend
* Internet
* Other sources like TV, radio or magazine
1. Based on the information you have just read, mark on the scale whether you are “less likely or “more likely” to choose a therapy that:

A series of shots given at the doctor’s office

Less likely to choose Neutral More likely to choose

1-----------------------------------------------------------3--------------------------------------------------5

Tablets that you put under your tongue, that are taken at home

Less likely to choose Neutral More likely to choose

1-----------------------------------------------------------3--------------------------------------------------5

Requires a visit to the doctor for shots weekly to build up to the maintenance dose and then monthly maintenance shots

Less likely to choose Neutral More likely to choose

1-----------------------------------------------------------3--------------------------------------------------5

Requires visits to the doctor to get a prescription for tablets and for follow-up

Less likely to choose Neutral More likely to choose

1-----------------------------------------------------------3--------------------------------------------------5

Might cause a serious side effect like anaphylaxis

Less likely to choose Neutral More likely to choose

1-----------------------------------------------------------3--------------------------------------------------5

Might cause local side effects like swelling where you get the shot

Less likely to choose Neutral More likely to choose

1-----------------------------------------------------------3--------------------------------------------------5

Might cause local side effects like swelling or itching under the tongue

Less likely to choose Neutral More likely to choose

1-----------------------------------------------------------3--------------------------------------------------5

Whether I have a drug plan that will pay for the treatment

Less likely to choose Neutral More likely to choose

1-----------------------------------------------------------3--------------------------------------------------5

1. If your allergist recommended SLIT allergy immunotherapy (tablets taken by mouth), how likely is it that you would try it, where 0 is not at all likely and 10 is very likely?

Not at all likely Neutral Very likely

1-----------------------------------------------------------3--------------------------------------------------5

1. If your allergist recommended SCIT allergy immunotherapy (shots taken at the allergist’s office), how likely is it that you would try it, where 1 is not at all likely and 5 is very likely?

Not at all likely Neutral Very likely

1-----------------------------------------------------------3--------------------------------------------------5