

ANNEXURE 1

RHINITIS CONTROL ASSESSMENT TEST (RCAT)

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

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

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

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

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

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

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

Not at all	A little	Somewhat	A lot	All the time
<input type="checkbox"/> ⁵	<input type="checkbox"/> ⁴	<input type="checkbox"/> ³	<input type="checkbox"/> ²	<input type="checkbox"/> ¹

5. **During the past week**, how often did you avoid any activities (for example, visiting a house with a dog or cat, gardening) because of your nasal or other allergy symptoms?

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

6. **During the past week**, how well were your nasal or other allergy symptoms controlled?

Completely	Very	Somewhat	A little	Not at all
<input type="checkbox"/> ⁵	<input type="checkbox"/> ⁴	<input type="checkbox"/> ³	<input type="checkbox"/> ²	<input type="checkbox"/> ¹

ANNEXURE 2

ANTERIOR RHINOSCOPY SCORE(EXAMINATION)













	<u>SCORE:</u>	<u>0</u>	<u>1</u>
1. NASAL DISCHARGE		NONE	MUCOID
2. NASAL MUCOSA COLOUR		PINK	PALE/BLUISH
3. NASAL OBSTRUCTION		MIST PRESENT	MIST ABSENT
(ON COLD SPATULA TEST)			
4. INFERIOR TURBINATE HYPERTROPHY		ABSENT	PRESENT

TOTAL:

ANNEXURE 3

DIETARY RECOMMENDATION HANDOUT PROVIDED TO PATIENTS IN THE DIETARY MODIFICATION GROUP

Allergic Rhinitis

क्या न खाएं / What not to eat			
Egg white	अंडे की सफेदी	انڈے کی سفیدی	
Tomato	टमाटर	ٹماٹر	
Peanuts	मूंगफली	مونگ پھلی	
Soyabean	सोयाबीन	سویا بین	
Tree nuts	अखरोट	اخروٹ	
Alcohol	शराब	شراب	
Vinegar	सिरका	سرکہ	
Spinach	पालक	پالک	
Sauerkraut	पत्तागोभी	پت گوبھی	
Chocolate	चॉकलेट	چاکلیٹ	
Preserved meat	रखा हुआ गोشت	محفوظ گوشت	
Almonds	बादाम	بادام	

ANNEXURE 4

DIETARY RECOMMENDATION HANDOUT PROVIDED TO PATIENTS IN THE PARELLEL STUDY

S. NO.	क्या खाएं / What to eat			क्या न खाएं / What not to eat		
1.	Figs	अंजीर		Egg white	अंडे की सफेदी	
2.	Mint	पुदीना		Tomato	टमाटर	
3.	Clove	लौंग		Peanuts	मूंगफली	
4.	Carrot	गाजर		Soyabean	सोयाबीन	
5.	Ashwagandha	अश्वगंधा		Tree nuts	अखरोट	
6.	Cinnamon	दालचीनी		Alcohol	शराब	
7.	Tulsi	तुलसी		Vinegar	सिरका	
8.	Onion	प्याज़		Spinach	पालक	
9.	Berries	जामुन		Sauerkraut	पत्तागोभी	
10.	Parsely	अजमोद		Chocolate	चॉकलेट	
11.	Apple	सेब		Preserved meat	रखा हुआ गोश्त	
12.	Sunflower Seed	सूरजमुखी के बीज		Almonds	बादाम	
13.	Rosemary	रोजमेरी				
14.	Garlic	लहसुन				
15.	Sweet potatoes	शकरकंद				
16.	Flax seed	अलसी				
17.	Mushrooms	मशरूम				
18.	Banana	केला				
19.	Mango	आम				
20.	Grapes	अंगूर				
21.	Pear	नाशपाती				
22.	Amla	आंवला				
23.	Coconut	गरी				
24.	Lemon	नींबू				
25.	White Pea	सफ़ेद मटर				