# Symptom Assessment

Pine Street Family Practice

Patient Name: ________________________________ Date of Birth:_____/_____/_____

Patient Phone: ________________________________ Today's Date:_____/_____/_____

| SYMPTOMS | SEVERITY | | | | FREQUENCY | | |
|---|---|---|---|---|---|---|---|
| | N/A | Mild | Moderate | Severe | Occasionally/ Never | Seasonal | Most of the Year/Daily |
| Itchy/Watery/Red Eyes | 0 | 1 | 2 | 3 | 0 | 1 | 2 |
| Runny/Itchy/Stuffy Nose | 0 | 1 | 2 | 3 | 0 | 1 | 2 |
| Headaches/Migraines | 0 | 1 | 2 | 3 | 0 | 1 | 2 |
| Frequent Throat Clearing | 0 | 1 | 2 | 3 | 0 | 1 | 2 |
| Frequent Sneezing | 0 | 1 | 2 | 3 | 0 | 1 | 2 |
| Sinus Pain and/or Pressure | 0 | 1 | 2 | 3 | 0 | 1 | 2 |
| Frequent Sneezing | 0 | 1 | 2 | 3 | 0 | 1 | 2 |

| | NO | YES |
|---|---|---|
| Have you ever been diagnosed with ***Asthma/Recurrent wheezing/Recurrent Bronchitis?*** | ☐ | ☐ |
| Have you ever been diagnosed with A***topic Dermatitis/Eczema, Recurrent Sinusitis?*** | ☐ | ☐ |
| Do you take prescription or ***OTC medications*** to manage your allergy symptoms? | ☐ | ☐ |

| Name of the above medications: | ☐ Allegra/Fexofenadine<br>☐ Claritin/Loratadine<br>☐ Xyzal/Levocetirizine<br>☐ Other: ____________ | ☐ Benadryl/Diphenhydramine<br>☐ Clarinex/Desloratadine<br>☐ Zyrtec/Cetirizine | Last Date Taken:<br>____/_____/____ |
|---|---|---|---|

☐ Signature________________________________ ☐ Patient ☐ Parent

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**OFFICE USE ONLY:**

**Sum of Severity (0-21)** _______ **Sum of Frequency (0-14)** _______

Order # 95004 ☐ YES ☐ NO Date of Last Physical Exam:____/_____/_____

Provider Signature: ____________________________ Date:_______/_______/_______