Allergy 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 |
| Sinus Pain and/or Pressure | 0 | 1 | 2 | 3 |  | 0 | 1 | 2 |
| Frequent Sneezing | 0 | 1 | 2 | 3 |  | 0 | 1 | 2 |
| Post Nasal Drip | 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 □ Benadryl/Diphenhydramine
* Claritin/Loratadine □ Clarinex/Desloratadine
* Xyzal/Levocetirizine □ Zyrtec/Cetirizine
* Other:
 | Last Date Taken: / /  |

* Signature □ Patient □ Parent

**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: / /