Allergy Assessment

Patient Name	Date of Birth	Today's Date

How often do you have these symptoms?	Never or Occasionally	Spring & Fall	Most of the year / Daily	Circle Severity
Watery / Itchy Eyes	☐	☐	☐	Mild Moderate Severe
Runny / Stuffy Nose	☐	☐	☐	Mild Moderate Severe
Itchy Nose	☐	☐	☐	Mild Moderate Severe
Seasonal Colds	☐	☐	☐	Mild Moderate Severe
Chronic Colds	☐	☐	☐	Mild Moderate Severe
Sinus Pressure / Pain	☐	☐	☐	Mild Moderate Severe
Post Nasal Drip	☐	☐	☐	Mild Moderate Severe
Frequent Sneezing	☐	☐	☐	Mild Moderate Severe
Consistent Coughing	☐	☐	☐	Mild Moderate Severe
Asthma	☐	☐	☐	Mild Moderate Severe
Itchy Mouth / Throat Clearing	☐	☐	☐	Mild Moderate Severe
Dry, Red, or Itchy Skin	☐	☐	☐	Mild Moderate Severe
Tension / Migraine Headaches	☐	☐	☐	Mild Moderate Severe
Restless Sleep / Snoring	☐	☐	☐	Mild Moderate Severe
Daytime Fatigue	☐	☐	☐	Mild Moderate Severe

How often do you use the following?	Never or Occasionally	Spring & Fall	Most of the year / Daily
Over-the-counter Antihistamine (Allegra, Claritin, Zyrtec, Benadryl, etc)	☐	☐	☐
Over the counter Nasal Spray	☐	☐	☐
Prescribed Nasal Spray	☐	☐	☐
Neti Pot	☐	☐	☐
Headache Medicine	☐	☐	☐

FOR PROVIDER USE ONLY

☐ **Allergy Test** ☐ **Other:** _____ **Provider Name:** _____

Notes: