WINTER ALLERGY ASSESSMENT

Patient Name: _____ Date of Birth: _____ Today's Date: _____

Do you experience any of these symptoms?

Please indicate any symptoms with a corresponding severity

Symptoms	Never	Seasonally	Most of the Year / Daily	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?

Antihistamine (Allegra, Claritin, Zyrtec, Benadryl, etc)	☐	☐	☐
Nasal Spray	☐	☐	☐
Headache Medicine	☐	☐	☐
Other Natural Remedies	☐	☐	☐

Please list any medications or treatments used:

Patient Signature: _____ **Date:** _____ **Phone Number:** _____

FOR PROVIDER USE ONLY

Provider Signature: _____ **Date:** _____

Allergy Test: **YES** ☐ **NO** ☐

Notes: