Chart Update

Name: _____ Date: _____
Contact Number: _____ DOB: _____

1. Do you experience any of the following symptoms: running nose, itchy nose, stuffy nose, itchy and/or watery eyes, or frequent sneezing? If you do, you may have allergies.

Is your medical history consistent with the symptoms above?
Yes No

2. Overall what is the severity of your allergy symptoms?
Mild Moderate Severe

3. Are your allergy symptoms present (please circle)
Rarely Seasonally (e.g. Summer/Spring only) ** Most of the year ***

4. Please circle the symptoms you suffer from and then circle the severity of the symptom(s).

a. Stuffy Nose	Mild *	Moderate **	Severe ***
b. Runny Nose	Mild *	Moderate **	Severe ***
c. Itchy Eyes	Mild *	Moderate **	Severe ***
d. Watery Eyes	Mild *	Moderate **	Severe ***
e. Itchy Throat	Mild *	Moderate **	Severe ***
f. Sneezing	Mild *	Moderate **	Severe ***

5. How often do you take prescription or over-the-counter medications for your allergies?
Not at all * Sometimes ** Frequently ***

6. Do you suffer from side effects such as dry mouth, drowsiness, or other effects?
Not at all * Sometimes ** Frequently ***