Chart Update

Name: _____ Date: _____

Contact Number: _____ DOB: _____

1. Do you experience any of the following symptoms?
   If so, you may have allergies. Please CIRCLE symptoms you experience.

Runny Nose	Itchy Nose	Stuffy Nose	Itchy or Watery Eyes	Frequent Sneezing	Wheezing
Dizziness	Skin Rashes	Headaches	Fatigue	Sinus Infections	Shortness of Breath
Congestion	Post Nasal Drip	Migraines	Coughing	Clogged Nose or Ears	Asthma

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 (ie. Summer/Spring only) ** Most of the Year ***

4. Please circle the symptoms you suffer from and 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***
   g. Headaches 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***