Wellness Update

Patient name	Date of birth	Today's date

How often do you have these symptoms?

Circle severity

	Never or Occasionally	Spring & Fall	Most of the Year/ Daily			
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	☐	☐	☐

Patient/guardian signature	Date	Patient phone

FOR PROVIDER USE ONLY:

Order Allergy Test: ☐ Yes ☐ No

Date of last ENT exam: ___/___/_____

Provider signature: _____

Date: ___/___/_____