Symptom Screening

Patient Name: _____ **Date of Birth:** _____ /_____ /_____

Patient Phone: _____ **Today's Date:** _____ /_____ /_____

	SEVERITY				FREQUENCY		
	N/A	Mild	Moderate	Severe	Occasionally/ Never	Seasonal	Most of the Year/Daily
Itchy Eyes	0	1	2	3	0	1	2
Watery Eyes	0	1	2	3	0	1	2
Red Eyes	0	1	2	3	0	1	2
Runny Nose	0	1	2	3	0	1	2
Itchy Nose	0	1	2	3	0	1	2
Stuffy Nose	0	1	2	3	0	1	2
Frequent Sneezing	0	1	2	3	0	1	2

	NO	YES
Have you ever been diagnosed with asthma?	☐	☐
Have you ever been diagnosed with atopic dermatitis?	☐	☐
Do you take prescription or over the counter medications to manage your allergy symptoms?	☐	☐

Name any of the above medications and last date taken: _____

_____

_____

_____

OFFICE USE ONLY:

Sum of Severity (0-21): _____ **Sum of Frequency (0-14):** _____

Order 95004: ☐ **Yes** ☐ **No** **Date of Last Physical Exam:** _____ /_____ /_____

Provider Signature: _____ **Date:** _____ /_____ /_____