

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

Have you ever been diagnosed with asthma? _____

NO YES

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: ____/____/____