SYMPTOM SCREENING

Patient Name: ____ Date of Birth:_____/_____/______

Patient Phone: __________________________________ Today's Date:____/_____/______

SYMPTOMS	SEVERITY				FREQUENCY		
	N/A	Mild	Moderate	Severe	Never	Seasonally or sometimes	Most of the Year/Daily
Red, Itchy or watery eyes	0	1	2	3	0	1	2
Runny or Itchy Nose	0	1	2	3	0	1	2
Stuffy Nose, congestion	0	1	2	3	0	1	2
Frequent Sneezing	0	1	2	3	0	1	2
Tingling or itching in the mouth	0	1	2	3	0	1	2

	YES	NO
Have you ever been diagnosed with ***Asthma, or Recurrent Wheezing/Bronchitis/Sinusitis*?**	☐	☐
Have you ever been diagnosed with ***Atopic Dermatitis/Eczema/Hives*?**	☐	☐
Have you been tested for environmental allergies in the past?	☐	☐
Have you been tested for food allergies in the past?	☐	☐

Have you taken any the following medications to manage allergy or inflammatory symptoms? ***Please check all that apply:***	☐ Allegra/Fexofenadine ☐ Claritin/Loratadine ☐ Zyrtec/Cetirizine ☐ Singulair/Montelukast ☐ Benadryl/Diphenhydramine ☐ Clarinex/Desloratadine ☐ Xyzal/Levocetirizine	☐ Aleve/Naproxen ☐ Aspirin ☐ Advil/Motrin ☐ Prednisone ☐ Other:	Last Date Taken: _____/_______/______

	YES	NO
Have you ever experienced a reaction to any foods?	☐	☐

Please check all symptoms that apply:	☐ Tingling/ Itchy mouth ☐ Hives/rash/eczema ☐ Swelling	☐ Wheezing/difficulty breathing ☐ Dizziness/ fainting ☐ Abdominal pain/ cramping	☐ Nausea/ vomiting ☐ Diarrhea ☐ Other:

☐ Signature_______________________________☐ Patient ☐ Parent

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SUM OF SEVERITY (0-15):	SUM OF FREQUENCY (0-10):		**ORDER 95004:**
			☐ YES ☐ NO
PROVIDER SIGNATURE:		DATE:	**Order sub Type:**
			☐ Environmental ☐ Food
			☐ Environmental & Food