Screening Assessment

Patient Name/MRN:_____ Today's Date:____/____/_____

Date of Birth:____/____/_____ Patient Phone: (___)____-_____

Symptoms	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
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
Migraine Headaches	0	1	2	3	0	1	2
Post-nasal Drip	0	1	2	3	0	1	2

Circle One

1. Have you ever been diagnosed with asthma, recurrent wheezing, or recurrent bronchitis?	Yes	No
2. Have you ever been diagnosed with atopic dermatitis, eczema, or recurrent sinusitis?	Yes	No
3. Do you take prescription or over-the-counter medications to manage your allergy symptoms? **Circle any that apply.**	Yes	No
Allegra (Fexofenadine) Xyzal (Levocetirizine) Benadryl (Diphenhydramine) Zyrtec (Cetirizine) Claritin (Loratadine) Singulair (Montelukast) Clarinex (Desloratadine) Other: _____		
4. Have you ever had a reaction to any foods in the past? If so, describe the event.	Yes	No
Circle the reaction(s) you experienced during the event(s):		
Tingling/itchy mouth Hives/rash/eczema Swelling Wheezing/difficulty breathing Abdominal pain/ diarrhea/nausea/vomiting Dizziness/lightheadedness/fainting		

If the answer to question 4 was "No", please skip questions 5 and 6.

5. Do you have any family members that have been diagnosed or have suspected allergies? If so, list those family members and their diagnosed/suspected allergies.	Yes	No
6. Have you ever been tested for food allergies?	Yes	No

Patient/Guardian Signature: _____ **Date:** _____

Office Use Only:			
Sum of severity of symptoms (0-21)	**Sum of frequency of symptoms (0-14)**	**Order 95004?**	
		Yes	No
		Circle Test(s)	
		Environmental	Food
Provider Signature:	**Date:**	Environmental & Food	