Allergy Intake Form

Patient Name: _____

Phone Number: _____

Email Address: _____

Provider's Name: _____

Circle all that apply

Do you suffer from seasonal allergies? Yes No

If yes: Sneezing | Itchy Eyes | Post Nasal Drip | Scratchy Throat | Congestion | Chronic Cough | Fatigue or Restlessness| Joint Pain

Additional symptoms: _____

Do you get sinus infections, frequent colds, flu or runny nose? Yes No

Have you been diagnosed with asthma? Yes No

Do you take any over-the-counter medications or prescription medications to relieve the symptoms? Yes No

If yes name of medications, and last date taken: _____

Would you like to know what you are allergic to? Yes No

Do you want to be allergy tested for pollens, molds and animals? Yes No

_____

Patient Signature Date