

# ***PATIENT INTAKE***

**Please circle all symptoms you currently have  
or have experienced in the past six months**



Itchy eyes  
Watery eyes  
Dry or red eyes



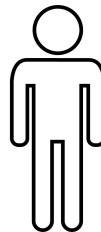
Sneezing  
Runny, stuffy nose  
Itchy nose  
Nasal drainage



Coughing  
Wheezing  
Shortness of breath  
Difficulty breathing  
Chest congestion  
Frequent colds  
Sore, scratchy throat  
Asthma  
Bronchitis  
Hay fever



Frequent headaches  
Difficulty sleeping  
Fatigue  
Sinus infections  
Sinus pressure  
Ear infections



Dry, red, or itchy skin  
Rashes, hives  
Eczema  
Frequent vomiting  
Frequent diarrhea  
Frequent stomach aches  
Celiac disease  
Sensitivity to pet hair  
Sensitivity to certain foods  
Anaphylaxis

**Do you take any of  
these medications?**

- Allegra
- Claritin
- Benadryl
- Zyrtec
- Sudafed
- Nasal sprays
- Eye drops
- Inhalers
- Prescribed allergy medications

**Please hand this form to the Medical Assistant  
when they call you back**