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Quality of Life Questionnaire- ALLERGIES

Patient's Name: _____ DOB: _____

1. Have you ever been diagnosed Allergies? YES ___ NO ___

2. Are you currently taking or have you within the last year or have been prescribed an over-the-counter or prescription strength medication for allergies, hay fever, or nasal congestion? YES ___ NO ___

If yes, please list all that apply:

_____

3. Have you ever been diagnosed with asthma? YES ___ NO ___

4. Is our doctor currently treating your asthma with medications? YES ___ NO___

If yes, please list all that apply:

_____

5. Please check any/all of the following symptoms that you experience more than three times in a month or for more than three consecutive months. Please note that in the case of seasonal allergies, you may not be experiencing those now, but may experience those now, but may experience them regularly during a different season of the year.

   Please check all that apply:

□ Stuff Nose	□ Itchy Throat	□Trouble Sleeping
□ Runny Nose	□ Sore Throat	□ Fatigue
□ Nasal Congestion	□ Cough	
□ Itchy Eyes	□ Post Nasal Drip	
□ Water Eyes	□ Headache	

Patient's Signature _____ Date: _____