

Wellness Update

Patient _____ Date of Birth _____ Today's Date _____

Do you experience any of these symptoms?	<i>Yes</i>	<i>No</i>
Runny Nose		
Itchy Nose		
Stuffy Nose		
Itchy Eyes		
Watery Eyes		
Frequent Sneezing		
Itchy Mouth/Lips/Throat		
Post Nasal Drip (drainage down the back of the throat, clearing throat)		

How often do you experience these symptoms?
<input type="checkbox"/> Occasionally (2-3 times per year) <input type="checkbox"/> Over 3 times a year <input type="checkbox"/> A few long periods of time per year (Spring, Summer, Fall, Winter) <input type="checkbox"/> Most of the year

Do you take prescription or over-the-counter (OTC) medications for the management of your allergy symptoms? Yes No

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

Please indicate below symptoms/conditions you've experienced during the last 1 – 2 years	
<input type="checkbox"/> Sinus related issues (sinus pressure/pain, headaches, sinusitis)	<input type="checkbox"/> Restless sleep, challenges sleeping through the night, snoring
<input type="checkbox"/> Re-occurring Seasonal Colds	<input type="checkbox"/> Consistent or Re-occurring coughing
<input type="checkbox"/> Chronic colds (lasting longer than 2 months)	<input type="checkbox"/> Feeling of fatigue, irritability, & restlessness
<input type="checkbox"/> Migraine Headaches	<input type="checkbox"/> Asthma
	<input type="checkbox"/> Skin conditions (dry and/or itchy skin, etc...)

Patient/Guardian Signature: _____

Date: _____

Patient Phone: _____

FOR CAT/CAS USE ONLY:

Date of Last ENT Exam: _____