ALLERGIC RHINITIS THERAPIES

PATIENT INFORMATION *(Please print clearly)*

Last Name: **First Name:**	**D.O.B.:** **Age:** **Gender:** **Height:** **Weight:**
Home Address:	Contact Phone:
City:	State: Zip:
Primary Care Physician:	Physician Phone:
Physician Address:	Physician Fax #:
Please state any past medical history and chronic conditions:	
Current medications:	
Allergies (please state reaction that occurs when exposed to the allergen):	

SCREENING QUESTIONNAIRE

	Yes	**No**	**Don't Know**
Do you currently have any of the following symptoms: Itchy nose, sneezing, nasal congestion, clear discharge?	☐	☐	☐
Do you have a history of recurrent nose bleeds or ear aches?	☐	☐	☐
Do you currently have symptoms of allergic rhinitis for greater than 4 days per week for at least the last 4 weeks?	☐	☐	☐
Do your symptoms of allergic rhinitis impair sleep or daily activities?	☐	☐	☐
Do you have any of the following symptoms: prolonged expiration, wheezing, difficulty breathing, cough?	☐	☐	☐
Do you have any of the following symptoms: puss-filled discharge, facial pain, fever?	☐	☐	☐
Do you have any of the following symptoms: loss of smell, stuffy nose without discharge or one-sided stuffiness, postnasal drip, weakness?	☐	☐	☐
For women: Are you currently pregnant or lactating?	☐	☐	☐
Do you currently smoke tobacco? *If yes, how many packs per day?*	☐	☐	☐
Do you currently consume alcohol? *If yes, how many drinks per day?*	☐	☐	☐
Do you currently use any recreational drugs? *If yes, please indicate which drugs and how often:*	☐	☐	☐