



Adult & Pediatric Allergy, Asthma and Skin Centers of North Alabama

Patient Survey

Name _____

Age _____ Date _____

Rate your symptoms when your allergies were most active?

Fatigue	0	1	2	3	4	5
Trouble sleeping	0	1	2	3	4	5
Irritability	0	1	2	3	4	5
Dizziness	0	1	2	3	4	5
Post-nasal drip	0	1	2	3	4	5
Sore throat	0	1	2	3	4	5
Sinus headache	0	1	2	3	4	5
Sneezing	0	1	2	3	4	5
Nasal itching	0	1	2	3	4	5
Nasal blockage	0	1	2	3	4	5
Nasal green/yellow mucus	0	1	2	3	4	5
Clear watery mucus	0	1	2	3	4	5
Loss of sense of smell	0	1	2	3	4	5
Snoring	0	1	2	3	4	5
Earache	0	1	2	3	4	5
Eye itching	0	1	2	3	4	5
Eye redness	0	1	2	3	4	5

Eye watering	0	1	2	3	4	5
Eye burning	0	1	2	3	4	5
Shortness of breath	0	1	2	3	4	5
Coughing	0	1	2	3	4	5
Wheezing	0	1	2	3	4	5
Chest tightness	0	1	2	3	4	5
Chest pain	0	1	2	3	4	5
Phlegm	0	1	2	3	4	5

Before you started treatment in this office, how many times did the following happen?

You missed work or school due to allergies, asthma, sinusitis, etc.

You went to the emergency room for an allergy-related problem

You had nose, ear or sinus surgery, including tube placement?

You used antibiotics for sinus, chest or ear infections

In the year before you started your current treatment, how many different daily medications including nasal sprays, inhalers, eye drops and pill, were you taking?

List only allergy and/or asthma medications