The Allergy Center of Georgia
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Screening Questionnaire

Patient Name _____
Date of Birth _____
Contact Number _____
Today's Date _____

Do you experience any of the following symptoms?	YES	NO	Frequency: Daily, Weekly, Monthly, Seasonal or All Year
Runny / Stuffy Nose, Frequent Sneezing, Post Nasal Drip			
Itchy / Dry / Watery Eyes			
Itchy / Dry Mouth, Throat or Ears			
Frequent Cough or Frequent Colds			
Seasonal Allergies			
Food Allergies			
Sinus Problems			
Restless, Poor Sleep or Snoring			
Fatigue or Irritability due to Restlessness or Poor Sleep			
Have you ever been told you have Asthma, RAD or Eczema?			
Have you ever used Albuterol?			
Have you ever been to an Allergist?			
Does your family have a history of Allergies?			

What Medicines have you used to control your symptoms in the past year? (Please Check)

1) *Over-the-Counter Medications*

a) Allergy / Cold Medications

_____ Claritin, Alavert, Zyrtec or Allegra

_____ Benedryl or Sudafed

_____ Cough, Cold or Sinus Medications

b) Over-the-Counter Nasal Sprays

_____ Nasal Saline, Nasal Washes or Neti Pot

c) Over-the-Counter Nasal Decongestants

	YES	NO
Are your symptoms well-controlled by these medications?		
Would you like to find out what you are allergic to in order for us to help you better control your allergy symptoms?		
Would you be interested in learning more about other treatment options available such as Immunotherapy, or allergy shots?		

You may speak with your provider at any time about options to help control your symptoms.

Provider Signature: _____