Allergy Questionnaire

Patient Name: ____ DOB: _________________ Date: __________________
(*If you are the parent filling out this form for your child(ren), please fill out only one form for the entire family. It is NOT necessary to fill out one for each child.)

Email: ____

Do you suffer from seasonal or year round allergies? Yes No

Do you experience any of the following symptoms? Please check all that apply.

___ Runny Nose	___ Itchy Eyes	___ Skin Rashes
___ Nasal Congestion	___ Fibromyalgia	___ Vertigo
___ Post Nasal Drip	___ Headache	___ Tinnitus
___ Sinusitis	___ Watery Eyes	___ Meniere's Disease
___ Asthma	___ Eczema/ Atopic Dermatitis	___Fatigue/ Trouble Sleeping
___ Diarrhea	___ Irritable Bowel Syndrome	___ Pre-Menstrual Syndrome

Other Symptoms ____

Would you like to consult with a provider at Broomfield Family Practice to discuss allergy treatment options? Yes No

Signature ____