Pediatric Wellness Update

Patient_____ **Date of Birth**_____ **Today's Date**_____

Does the patient experience any of these symptoms?	*Yes*	*No*
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 does the patient experience these symptoms?

- ☐ Occasionally (2-3 times per year)
- ☐ Over 3 times a year
- ☐ A few long periods of time per year (Spring, Summer, Fall, Winter)
- ☐ Most of the year

Does the patient take prescription or over-the-counter (OTC) medications for the management of his/her allergy symptoms? ☐ **Yes** ☐ **No**

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

Please indicate below symptoms/conditions the patient experienced during the last 1 – 2 years

- ☐ Sinus related issues (sinus pressure/pain, headaches, sinusitis)
- ☐ Re-occurring Seasonal Colds
- ☐ Chronic colds (lasting longer than 2 months)
- ☐ Headaches
- ☐ Restless sleep, challenges sleeping through the night, snoring
- ☐ Consistent or Re-occurring coughing
- ☐ Feeling of fatigue, irritability, & restlessness
- ☐ Asthma
- ☐ Skin conditions (dry and/or itchy skin, etc…)

Parent Name (Print):_____ **Phone:**_____

Parent Signature:_____ **Date:**_____

FOR CAT/CAS USE ONLY - Date of Last ENT Exam:_____