Symptom Summary

Santa Fe Center for Allergy & Environmental Medicine

Name: _____ Date _____

Please score your all of your current symptoms by placing check marks in the appropriate spaces. If a symptom is not included, please include in the spaces at the bottom. If you don't have a symptom, don't check any boxes for that symptom.

	Symptoms	1 Mild	2 Moderate	3 Bad	4 Very Bad	Seasonal Only?
1.	Nasal symptoms (runny, stuffy, etc.)	_____	_____	_____	_____	_____
2.	Post nasal drip	_____	_____	_____	_____	_____
3.	Sneezing	_____	_____	_____	_____	_____
4.	Irritated throat	_____	_____	_____	_____	_____
5.	Watery, itchy or swollen eyes	_____	_____	_____	_____	_____
6.	Coughing	_____	_____	_____	_____	_____
7.	Wheezing/asthma	_____	_____	_____	_____	_____
8.	Ear problems	_____	_____	_____	_____	_____
9.	Sinus pain	_____	_____	_____	_____	_____
10.	Headaches/migraine	_____	_____	_____	_____	_____
11.	Fatigue, tiredness	_____	_____	_____	_____	_____
12.	Spaciness, trouble thinking	_____	_____	_____	_____	_____
13.	Hives, facial swelling	_____	_____	_____	_____	_____
14.	Rash, skin irritation, severe itching	_____	_____	_____	_____	_____
15.	Joint pains/swelling, muscle pains	_____	_____	_____	_____	_____
16.	Autoimmune disease	_____	_____	_____	_____	_____
17.	Gas, bloating	_____	_____	_____	_____	_____
18.	Abdominal pain	_____	_____	_____	_____	_____
19.	Constipation	_____	_____	_____	_____	_____
20.	Diarrhea	_____	_____	_____	_____	_____
21.	Vaginitis	_____	_____	_____	_____	_____
22.	PMS	_____	_____	_____	_____	_____
23.	Depression	_____	_____	_____	_____	_____
24.	_____	_____	_____	_____	_____	_____
25.	_____	_____	_____	_____	_____	_____