

Symptom Summary

Santa Fe Center for Allergy & Environmental Medicine

Name: _____

Date _____

Please score your current overall symptoms by placing check marks in the appropriate spaces. If one or more of your symptoms are not included, please include and score in the spaces at the bottom.

Symptoms	0 None	1 Mild	2 Moderate	3 Bad	4 Very Bad
1. Nasal Symptoms (runny, stuffy, etc.)	_____	_____	_____	_____	_____
2. Post nasal drip	_____	_____	_____	_____	_____
3. Sneezing	_____	_____	_____	_____	_____
4. Rash, skin irritation	_____	_____	_____	_____	_____
5. Hives	_____	_____	_____	_____	_____
6. Watery, itchy or swollen eyes	_____	_____	_____	_____	_____
7. Irritated throat	_____	_____	_____	_____	_____
8. Wheezing	_____	_____	_____	_____	_____
9. Coughing	_____	_____	_____	_____	_____
10. Sinus pain	_____	_____	_____	_____	_____
11. Headaches	_____	_____	_____	_____	_____
12. Ear problems	_____	_____	_____	_____	_____
13. Fatigue, tiredness	_____	_____	_____	_____	_____
14. Joint, muscle pains	_____	_____	_____	_____	_____
15. PMS	_____	_____	_____	_____	_____
16. Gas, bloating	_____	_____	_____	_____	_____
17. Abdominal pain	_____	_____	_____	_____	_____
18. Constipation	_____	_____	_____	_____	_____
19. Diarrhea	_____	_____	_____	_____	_____
20. Depression	_____	_____	_____	_____	_____
21. Vaginitis	_____	_____	_____	_____	_____
22. _____	_____	_____	_____	_____	_____
23. _____	_____	_____	_____	_____	_____
24. _____	_____	_____	_____	_____	_____
25. _____	_____	_____	_____	_____	_____

