East Cobb Pediatrics & Adolescent Medicine, PC.
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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		
Water 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 per 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-occuring 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...)

	Yes	No
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 (Allergy Shots)?		

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

Parent Signature:_____ **Date:**_____

FOR CAT/CAS USE ONLY- Date of Last ENT Exam_____

Provider Signature:_____