Allergy & ENT IMMUNOTHERAPY RE-EVALUATION

NAME: ______________________________ DATE: ______________

On a scale of 1 to 10, note the severity of symptoms that you were having **before** receiving allergy injections and the symptoms you are **now** experiencing. (10 is the **worst** and 0 is **no symptoms**) Use N/A if symptom does not apply to you.

	Now	**Before**
Itchy, watery nose		
Itchy, watery eyes		
Sinus congestion/Nasal blockage		
Sneezing		
Headaches		
Asthma/Bronchitis		
General health		
Totals		

1. Are your symptoms seasonal only? ____________ Which months? ____________________
2. Are your symptoms year round? _________ Are certain months worse? ________________

   ____

3. In addition to immunotherapy, what medications do you take for your allergies and how often? ____

   ____

   ____

4. How many days of school or work did you miss on average per year before shots and currently? Before?_______________ Currently? ________________
5. Do you think allergy injections are helping you?____________________________________

   ____

   11/00

   CIT12.00.00

6.