



## Allergy Screening Questions

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|---|-----|---------------|
| 1. On average, how many days per week do you have symptoms?   | < 4 | > 4 days/week |
| 2. How many weeks have you had these symptoms?                | < 4 | > 4           |
| 3. Are you sleeping normally?                                 | Yes | No            |
| 4. Do your symptoms interfere with social activities?         | Yes | No            |
| 5. Do your symptoms interfere with work or school activities? | Yes | No            |
| 6. Do your symptoms bother you?                               | Yes | No            |