Unity Health

REQUEST FOR REPEAT HAY FEVER MEDICATION

For Office use only;
Date Received;

Please complete the following questions in order that the correct medication is issued for your hay fever symptoms. **Please write clearly.**

Different medication may be prescribed if it is felt more appropriate to your hay fever symptoms. If you wish to discuss this further please make an appointment with the practice nurse.
Thank you

Name: _____ Date of Birth _____

Address: _____

Telephone/mobile no: _____

When does your hay fever generally start? _____

Do your symptoms occur less than 4 days per week? _____

Do your symptoms occur more than 4 days per week & for more than 4 weeks? _____

Do you have the following symptoms?: *Please tick.*

Blocked nose	yes	no
Runny/itchy nose	yes	no
Sneezing	yes	no
Do you have itchy/watery eyes	yes	no
Does it affect daily activities?	yes	no
Does it affect your sleep?	yes	no
Do you suffer from asthma	yes	no
Is this made worse by your Hay Fever	yes	no
Do you smoke	yes	no
Are you pregnant	yes	no

Which hay fever medication do you take? _____

Have you tried any other hay fever medication before? Please state which if known _____

_____

How effective is it?: Very good Satisfactory Poor

Would you like to try a different hay fever medication? Yes No

Which repeat hay fever medication do you want issued: _____

_____

Which Pharmacy would you like to collect your prescriptions from_____ (via EPS)
Or, indicate that you would prefer to collect your prescription from;
York Campus / Hull Road Surgery / Wenlock Terrace (please circle)

Please allow 48hrs from request to collection

Thank you for completing this form.