

ALLERGY INJECTION HISTORY FORM

NAME _____

NU ID# _____

	Yes	No
1) What is the date of your last allergy physician visit?		
2) Have you ever been diagnosed with asthma?		
3) Do you use a home peak flow meter?		
4) Do you use a home nebulizer?		
5) How long have you been getting allergy injections? Please circle: 1-6 months 1-2 yrs 5 or more years		
6) Have you ever had any local reactions after an allergy injection?		
-Itching localized to area of exposure		
-Rhinitis		
-Red eyes		
-Nasal passage blockage (stiffness)		
-Sneezing		
7) Have you ever experienced any of the following systemic reactions after an allergy injection?		
-History of shortness of breath		
-Wheezing		
-Cough		
-Gasping for breath		
-Allergic hives (urticaria)		
-Angioedema		
-Itching generalized		
-Sudden redness of the skin (flushing)		
-Low blood pressure		
-Chest discomfort		
-Dizziness		
-Headache		
-Difficulty swallowing (dysphagia)		
-Abdominal pain		
-Nausea		
-Diarrhea		
-Excessive sweating		
8) Has your physician given you advice on what to do if there is a reaction? _____		
9) List current medications: _____		

The above history is accurate to the best of my knowledge.

Patient Signature

Date