

All questions contained in this questionnaire are strictly confidential and will be added to your medical record.

Name *(Last, First, M.I.)* _____ Date of Birth _____

PERSONAL HEALTH HISTORY

Do you have an EpiPen? Yes
 No

Have you ever been diagnosed with Asthma? Yes
 No

Have you ever received allergy injections? Yes
 No
If yes, when: _____

Please list current medications

Please list current allergies including medication, environmental and food

Allergy Physician _____

What was the date of your last allergy physician visit? _____

COMPLETE THE FOLLOWING IF YOU HAVE EVER HAD ALLERGY INJECTIONS

Have you ever had any local reactions after an allergy injection? **Yes**
No

Previous treatment advised by your physician for local reactions

Itching localized to area of injection
Redness localized to the area of injection
Swelling localized to the area of injection
Other local reactions _____

Have you ever had any systemic reactions after an allergy injection? **Yes**
No

Previous treatment advised by your physician for systemic reactions

Skin

- Allergic hives
- Sudden onset of swelling of eyes, hands and/or feet
- Generalized itching
- Sudden redness of skin (flushing)

Other

- Difficulty swallowing
- Abdominal pain
- Nausea
- Diarrhea
- Excessive sweating
- Red eyes, moderate to severe

Other systemic reactions _____

Cardiovascular

- Low blood pressure
- Chest discomfort
- Dizziness
- Headache

Respiratory

- Runny nose
- Nasal Stuffiness
- Sneezing
- History of shortness of breath
- Wheezing
- Cough