UNIVERSITY HEALTH CENTER
by Nebraska Medicine

ALLERGY HISTORY QUESTIONNAIRE
(NEW PATIENT)

University of Nebraska Lincoln

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

Cardiovascular
- ☐ Low blood pressure
- ☐ Chest discomfort
- ☐ Dizziness
- ☐ Headache

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

Other systemic reactions _____

_____

_____

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