Patient Name: _____ Patient DOB: ___/___/_____ Date: ___/___/_____

PATIENT HISTORY

Medical Conditions		Additional Information
High blood pressure	☐ YES ☐ NO	
Heart Disease	☐ YES ☐ NO	
COPD/Chronic Bronchitis	☐ YES ☐ NO	
Uncontrolled Asthma	☐ YES ☐ NO	
Stroke	☐ YES ☐ NO	
Immune Disorders (HIV, rheumatoid arthritis, cancer, etc)	☐ YES ☐ NO	

Are you pregnant? ☐ YES ☐ NO ☐ N/A

Do you have the skin condition called ***dermographism***? ☐ YES ☐ NO

Have you ever had a severe anaphylactic (allergic) reaction that required emergency medical attention? If yes, explain: ☐ YES ☐ NO _____

List all current medications, including prescribed and OTC medications:

NAME	TAKEN FOR	DOSE/FREQUENCY	DATE STARTED	LAST TIME TAKEN

Allergy History

When did allergies begin? (Year) _____

Do symptoms include itching and sneezing? ☐ YES ☐ NO

When do symptoms occur? (check all that apply)

☐ All months
☐ January
☐ February
☐ March
☐ April
☐ May
☐ June
☐ July
☐ August
☐ September
☐ October
☐ November
☐ December

When are symptoms worse?

☐ Morning
☐ At home
☐ Afternoon
☐ At work
☐ Constant
☐ Evening
☐ At school
☐ Occasional
☐ Night
☐ Other location: _____
☐ Rare

Symptoms are:

Symptoms interfere with activities:

☐ Not at all
☐ Mildly
☐ Moderately
☐ All the time

Which of the following cause or make symptoms worse? (Check all that apply)

FOOD

☐ Meat
☐ Beer
☐ Nuts
☐ Liquors
☐ Wine
☐ Cheese
☐ Chicken
☐ Other: (list all) _____
☐ Mushrooms
☐ Poultry
☐ Vinegar
☐ Milk / milk products
☐ Fish
☐ Eggs/egg products
☐ Fruit juices
☐ Wheat products
☐ Vegetables

Patient Name: _____ Patient DOB: ___/___/_____ Date: ___/___/_____

ENVIRONMENT

- ☐ Wind
- ☐ Soap
- ☐ Paint fumes
- ☐ House plants
- ☐ Cold day
- ☐ Hay
- ☐ Stuffed toys
- ☐ Smoke
- ☐ Powder
- ☐ Perfumes
- ☐ Weather change
- ☐ Air-conditioning
- ☐ Cut grass
- ☐ Furniture
- ☐ Barns/Hay
- ☐ Mowing lawns
- ☐ Cosmetics
- ☐ Wet weather
- ☐ Travel
- ☐ Cut flowers
- ☐ Other: (list all) _____
- ☐ High pollution
- ☐ Insecticides
- ☐ Newspapers
- ☐ Dry weather
- ☐ Household plants
- ☐ Rugs/rug pads
- ☐ Damp areas
- ☐ Dust
- ☐ Wool
- ☐ Hot day
- ☐ Feather pillows
- ☐ Christmas trees

Indoors, explain: _____

Outdoors, explain: _____

PETS

☐ Birds ☐ Cat Indoor / Outdoor ☐ Dog: Indoor / Outdoor ☐ Cattle ☐ Horse

☐ Other: (list) _____

Place X under self or age of family members with any of the following medical conditions:

Condition	Self	Father	Mother	Brothers	Sisters	Children
Migraine						
Hay Fever						
Hives						
Eczema						
Asthma						
Food Allergies						

Allergy Care History

List any OTC or Prescribed medications taken for allergy symptoms and when:

NAME	DOSE/FREQUENCY	DATE STARTED	LAST TIME TAKEN

Other

Have you (patient) had an allergy shot in the last two weeks? ☐ YES ☐ NO If yes, explain _____

Have you (patient) had any vaccine within the last 48 hours? ☐ YES ☐ NO If yes, explain _____

Do you (patient) have an allergy to latex? ☐ YES ☐ NO If yes, explain _____

Do you (patient) have an allergy to rubbing alcohol? ☐ YES ☐ NO If yes, explain _____

Do you (patient) have an allergy to any medications? ☐ YES ☐ NO If yes, explain _____

For Provider Use Only:

NOTES:

_____ _____ ___/___/_____

Patient/Guardian Printed Name Patient/Guardian Signature Date

_____ _____ ___/___/_____

Provider Printed Name Provider Signature Date

atient Name: _____ Patient DOB: ___/___/_____ Date: ___/___/_____

INFORMED CONSENT FOR ALLERGY TESTING

I, _____*(patient name)*, consent to receive an allergy skin prick test by or under the supervision of my provider to help determine the cause of my allergy symptoms.

An allergy skin prick test consists of introducing small amounts of allergens into the skin by lightly scratching the skin with a specially designed applicator containing each allergen and noting any development of a positive reaction. Results are read 15 to 20 minutes after the application of the test. Positive reactions to an allergen will gradually disappear over a period of time.

Reactions from this procedure may occur and I will inform the medical staff of any reactions I may experience. These reactions may consist of any or all of the following symptoms: itchy eyes, nose, or throat, nasal congestion, runny nose, tightness in the throat or chest, increased wheezing, lightheadedness, faintness, nausea or vomiting, hives, generalized itching, bleeding at puncture site, hives and redness of skin. Although rare, under extreme circumstances, serious reactions may result in significant respiratory reactions, or anaphylactic shock, which may be life threatening. I consent and authorize the treatment of any reactions that may occur as a result of allergy testing.

I verify that I am not currently pregnant or if I am, I have discussed the risks/benefits with my provider. Allergy skin testing should be postponed until after the pregnancy. I verify that I am not currently taking beta-blocker medication or if I am, I have discussed risks/benefits with my provider. Beta-blockers are medications that may interfere with treatment of an adverse reaction.

I have been advised that some medications I may be taking could interfere with allergy testing. If it is determined that medication I am taking has interfered with testing data, I understand that testing may need to be repeated at a later time.

I have read this form and I fully understand its contents. The opportunity has been provided for me to ask questions about my allergy skin prick test and these questions have been answered to my satisfaction.

_____	_____	___/___/_____
Patient/Guardian Printed Name	Patient/Guardian Signature	Date
_____	_____	___/___/_____
Witness Printed Name	Witness Signature	Date

Patient Name: _____ Patient DOB: ___/___/_____ Date: ___/___/_____

ELECTRONIC CONSENT CONTACT FORM

Patients may elect to receive communications via email, mobile text, and phone regarding personal medical information. By allowing the provider to communicate using this method, patients may receive appointment alerts as well as immunotherapy updates. Please be assured that all information will be kept confidential.

By my signature below, I agree that:

1) I would like to receive Short Message Service (SMS) messages and/or email pertaining to my allergy treatment, including, patient appointment or treatment reminders and other allergy related educational information to assist me in my allergy treatment;
2) I would like to receive a SMS message (as described above) through my communication service provider in order to deliver the SMS message to the mobile number listed below;
3) My communication services provider is acting as my agent in this capacity; and
4) I am providing a valid email and/or mobile phone number for these email and/or SMS messaging services.

There are no charges imposed by my provider for SMS message services, but I am responsible for any and all applicable charges or fees imposed by my communications service provider.

Patient Name: _____

Patient/Guardian Signature: _____

Patient E-Mail Address: _____

Patient Mobile Number: _____

Patient Mobile Carrier: _____

Note: *Consent for receipt of email or mobile text messages is not required as a condition of any allergy service or treatment. Consent to receive SMS and/or email notifications may be revoked at any time by following the "opt out" instructions included in the SMS communication copy that is sent to the email address listed. Please allow a reasonable period of time to process your withdrawal. The provider may terminate text and/or email messaging services from time to time, for any reason, and without notice.*