Allergy Injection Intake Form

To be completed before beginning allergy injections at the McGrath Health and Wellness Center.

Name____________________________________________________ Date________________________

When did you start getting allergy shots?___________________________________________________

When was your last shot?______________________________________________________________

During what months are your allergy symptoms worse?_____________________________________

Do you have any kind of heart disease or abnormality?  Y_____ N_____
If yes, please
describe___________________________________________________________________________

Have you ever had asthma or wheezing?  Y_____ N_____
If yes, please
describe___________________________________________________________________________

Have you ever been admitted to the hospital for asthma treatment?  Y_____ N_____
If yes, please
describe___________________________________________________________________________

Have you gone to the emergency room for asthma treatment?  Y_____ N_____
If yes, please
describe___________________________________________________________________________

Have you ever had wheezing or asthma as a reaction to an allergy shot?  Y_____ N_____
If yes, please
describe___________________________________________________________________________

Have you ever had hives or rashes or any kind of generalized reaction to an allergy shot?  Y_____ N_____
If yes, please
describe___________________________________________________________________________

Are you taking any medications? Include the prescribed and over the counter.  Y_____ N_____
If yes, please list___________________________________________________________________________

(Rev. 5/12 pl)