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 7/14 MR