Allergy Immunotherapy Initial Visit Questionnaire

To be completed by Patient, Parent or Legal Guardia	an:			
To what are you allergic? Please check all that apply:				
□ Pollen □ Dust □ Trees □ Grass □ Mold □ F	Tur/Dande	r		
☐ Insect venom		•		
☐ Medicine				
☐ Medicine ☐ Foods ☐ Oth	er			
Have you ever had a severe allergic reaction to anything	r? □ ves	\square no		
Describe.	,. ш усь			
Describe:	□ves	□ no		
Do you carry an Epi-1 cm.	□ усз			
Are you currently taking any medications?	□ yes	□no		
	•		☐ Retablocker(s):	
☐ Antihistamine: ☐ Inhaler(s): ☐ Other meds:			\(\text{\text{Detablocker}(s)}. \)	_
☐ Other meds: Are your allergy prescriptions up to date?	□ yes	Ппо		
Are your anergy prescriptions up to date:	□ yes			
Are you currently receiving allergy shots?	□ yes	Ппо	If was far have lang?	
3 6 63			If yes, for how long?	
Have you ever had a reaction to you allergy shots?		□ no		
If yes, was it: \Box while in the clinic \Box after leaving the	ne clinic			
Describe reaction:				_
Do you have asthma?	□ yes	□ no		
Do you smoke?	□ yes	□ no		
Do you have any other medical conditions?	\square yes	□ no		
Describe:				_
Signature Patient, Parent or Legal Guardian:			Date:	
Signature Patient, Parent or Legal Guardian:			Date:	
Signature Patient, Parent or Legal Guardian: To be completed by UCM Health Center Clinician:			Date:	
			Date:	
To be completed by UCM Health Center Clinician: Records received from allergist include:				
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To be completed by UCM Health Center Clinician:				
To be completed by UCM Health Center Clinician: Records received from allergist include: Physician's name Address_ Phone # fax # □ Diagnosis being treated				_
To be completed by UCM Health Center Clinician: Records received from allergist include: Physician's name Address Phone # fax #				_
To be completed by UCM Health Center Clinician: Records received from allergist include: Physician's name Address Phone # fax # □ Diagnosis being treated □ Antigen name □ Dilution □ Dose □ Schedule □ Ex				_
To be completed by UCM Health Center Clinician: Records received from allergist include: Physician's name Address_ Phone # fax # □ Diagnosis being treated □ Antigen name □ Dilution □ Dose □ Schedule □ Ex □ Interval between injections □ Missed dose schedule				
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To be completed by UCM Health Center Clinician: Records received from allergist include: Physician's name	ior to show office Clinic Info nutes after	late sheet er injection	Contact Person ons contacted before shots are initiated.	
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