Allergy Shots Intake Form

To be completed before beginning allergy injections at the Health Center:

Name_________________________________________    Date__________________

When did you start getting your allergy shots?_____________________________

When was your last shot?_______________________________________________

Are you getting shots containing insect venom?__________________________

During what months are your allergy symptoms worse?____________________

Do you have any kind of heart disease or abnormality? □Yes □No
□Yes   □No
If yes, please describe________________________________________________

Have you ever had asthma or wheezing? □Yes □No
If yes:  Have you ever been admitted to the hospital for asthma treatment? □Yes □No

Have you gone to the emergency room for asthma treatment? □Yes □No

Have you ever had wheezing or asthma as a reaction to an allergy shot? □Yes □No

Have you ever had hives or rashes or any kind of generalized reaction to an
allergy shot? □Yes □No
□Yes  □No
If yes, please describe________________________________________________

Are you taking any medications? (include prescribed and over the counter) □Yes □No
If yes, please list______________________________________________________