

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

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

If yes, please describe _____

Are you taking any medications? (include prescribed and over the counter) Yes No

If yes, please list _____
