ALLERGY INTAKE FORM

Name: ______________________________________ Phone Number: ____________________ DOB: ___/___/_____

Provider's Name: ____________________________________ Date of Visit: ___/___/_____

CIRCLE ALL THAT APPLY:

Do you suffer from allergies? YES NO

If **yes**, which seasons: SPRING SUMMER FALL WINTER ALL YEAR

If **yes**, which of the following symptoms do you typically have:

-SNEEZING -ITCHY AND/OR WATERY EYES -SCRATCHY THROAT -CONGESTION -CHRONIC COUGH

-FATIGUE -RESTLESSNESS -POST NASAL DRIP -JOINT PAIN -ITCHY DRY SKIN -HIVES -RUNNY NOSE

OTHER: ____

How long have you had these symptoms?______years__months

When do you typically experience them the most: Morning Afternoon Night All Day

YES NO Do you frequently get sinus infections, colds, flu or a runny nose?

YES NO Have you been diagnosed with Asthma? If **yes**, is it controlled? YES NO

YES NO Do you take any antihistamine medications to control these symptoms? If yes, please list them below & date last taken:

Please list **ALL** medications you are currently on, and the date last taken:

____

____

YES NO Are you Pregnant? If **no**, are you planning on becoming pregnant within the next year? YES NO

YES NO Are you HIV positive or have AIDS?

YES NO Are you taking any Beta Blocker Medications? If **yes**, which one: ____________________

YES NO Are you taking any Antibiotic Medications? If **yes**, which one: ____________________

YES NO Do you have any Auto Immune Diseases? If **yes**, which one: ____________________

YES NO Have you been Allergy Tested in the last 12 months? If **yes**, are you on immunotherapy? YES NO

YES NO Are you planning on relocating within the next 12 months?

YES NO Have you ever had a life-threatening allergic reaction and need emergency medical attention?

YES NO Do you have Dermagraphism?

YES NO Do you have any known food allergies? If **yes**, which one: ___________________________________

Patient Signature:____ Date: ___/___/____

Allergy Tech Name: _________________________________ Allergy Tech Signature: ___________________________

Allergy Diagnosis- (OFFICE USE ONLY)

Patient Name: ______________________________________ DOB: ___/___/____ DOS: ___/___/____

Code: ____ BP: ___/___ Pulse: ___bpm Peak Flow:____

Diagnosis

Nose and Sinus	
J30.0	Vasomotor
Upper Respiratory	
J45.20	Mild intermittent asthma, Uncomplicated
J45.30	Mild persistent asthma, Uncomplicated
J45.40	Moderate persistent asthma, Uncomplicated
J45.50	Severe persistent asthma, Uncomplicated
Allergies	
J30.1	Rhinitis due to pollen (Hay Fever)
J30.2	Other seasonal allergic rhinitis
J30.5	Rhinitis due to food
J30.81	Rhinitis due to animal hair and dander
J30.89	Other allergic rhinitis
Eye	
H10.45	Other chronic allergic conjunctivitis
H10.411	Chronic giant papillary conjunctivitis, Right Eye
H10.412	Chronic giant papillary conjunctivitis, Left Eye
H10.413	Chronic giant papillary conjunctivitis, Bilateral

Patient previously seen, treated, or complained about listed symptoms: YES NO
Referred for Allergy Testing: YES NO
Provider Notes:

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Medications to remain off (if any): ____

Provider Signature: ______________________________