

ALLERGY INJECTION INTAKE FORM

Name _____ Date _____

- 1. How long have you been receiving allergy injections? _____
- 2. When were you last injection? _____
- 3. Have you ever had any type of reaction after your injection? _____
If yes, please explain: _____

- 4. Do your shots contain insect venom/antigen to bee stings? _____
- 5. Do you take shots year round? _____
- 6. Do you have any heart disease or abnormalities? _____
If yes, please explain: _____

- 7. Do you have asthma? _____
- 8. Do you every have wheezing? _____
- 9. Have you ever been admitted to the hospital or gone to the emergency room for asthma? _____
- 10. Have you ever had wheezing or asthma from you allergy shot? _____
- 11. Have you ever had hives/other symptoms after your allergy shot? _____
- 12. Are you presently taking any medications? _____
If yes, please list: _____

Patient Name Date of Birth Signature of Patient/Patient Representative Date

Print Name if signed by other than patient Witness Signature