Consent Form for Allergy Testing and Treatment

The purpose of this form is to ensure that your decision to have this evaluation and treatment is made with the knowledge of the possible risks of this medical care.

- Generalized allergic reactions after skin testing are unusual and very rare, but their possible occurrence should be noted.
- A local reaction (at the test site) may appear as redness, itching, or localized swelling.
- A moderate reaction may appear as rapid or weak pulse rate, in rare cases there may be some shortness of breath.
- The list of medications that interfere with Allergy Testing has been reviewed with me. ________
- I understand that Beta Blockers can affect the effectiveness of epinephrine in the event of anaphylatic shock. ________

  - ☐ I am currently taking Beta Blockers.
  - ☐ I am not currently taking Beta Blockers

These symptoms may require immediate treatment, initiated in this office and possibly continued in a hospital setting.

I have read and understand the purpose of allergy testing, the testing techniques used, and the risks involved.

I authorize ______________________________________ and his/her medical staff, to perform allergy testing and the ordering of immunotherapy for treatment.

Signature ___________________________________ Date ________________

Relative Signature ______________________________________ *(If minor)*

Relationship to Minor _________________________________

Witness Signature_____________________________________

Witness Name _____________________________________

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HEALTHCARE
AN AFFILIATE OF MEDICAL MANAGEMENT SERVICES

Allergy Patient Medical History Form

Patient Name: ______________________________

Age: _____ Sex: ______ DOB: ___/____/_______

Patient Number: ____________________________

Patient Label

A. How many of the following have you experienced?

- ☐ Fatigue
- ☐ Fever
- ☐ Weight Gain
- ☐ Drainage
- ☐ Wheezing
- ☐ Diabetes
- ☐ Weakness
- ☐ Weight Loss
- ☐ Dizziness
- ☐ Headache
- ☐ Thyroid, High or Low
- ☐ Swollen Lymph Nodes
- ☐ Itching, Rash, Hives
- ☐ Persistent Cough
- ☐ Anaphylaxsis (Swelling of tongue or throat, tightening of chest)
- ☐ Allergic Reaction, *specify* ____________________

B. Allergy Symptoms: *(please check beside all that apply)*

- ☐ Blurred vision: *Left, Right or Both*
- ☐ Pain/redness in eyes
- ☐ Itchy eyes
- ☐ Watery eyes
- ☐ Hoarseness
- ☐ Smell or taste change
- ☐ Dizziness
- ☐ Drainage
- ☐ Itching throat
- ☐ Snoring
- ☐ Ringing in ears
- ☐ Headaches
- ☐ Itching (general)
- ☐ Rash
- ☐ Hives
- ☐ Depression
- ☐ Tremor
- ☐ Anxiety
- ☐ Persistent cough
- ☐ Wheezing
- ☐ Shortness of breath
- ☐ Chest pain
- ☐ Palpitation
- ☐ No sleep/Insomnia

Are these symptoms constant or intermittent?

____

____

During which months do you usually have symptoms?

____

____

Do you have any known food allergies? ____

____

C. Medical Information: *(please check beside all that apply)*

What medications (prescription and OTC) do you take or have taken? For how long?
(Please indicate inhalers and nasal sprays)

- ☐ Aspirin
- ☐ Cortisone
- ☐ Tranquilizers
- ☐ Sedatives
- ☐ Birth Control
- ☐ Antibiotics
- ☐ Vitamins
- ☐ Ointments
- ☐ Nose Drops/Sprays
- ☐ Hormones
- ☐ Thyroid Medication
- ☐ High Blood Pressure Medications
- ☐ Antihistamines
- ☐ Decongestants
- ☐ Anticholesterol Medications (Cholestramine)

List Others

____

____

____

____

In your experience, have any medications provided you relief of your allergy symptoms?______________________

____

Tobacco Use

- ☐ Never Smoked
- ☐ Current, Everyday Smoker
- ☐ Former Smoker (Quit Date: _________)
- ☐ I Live With a Smoker

Have you ever been tested for allergies? ☐ No ☐ Yes

If Yes ☐ Within past 3-6 months ☐ Within past 6-12 months ☐ Over 12 months

Office Use Only:

☐ Yes ☐ No

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Gardner Dermatology & MED SPA

Allergy Patient Medical History Form

D. Environmental Survey:

Do you use a HEPA filter? ☐ Yes ☐ No

If so, how often do you replace it?____

Do you have carpets in your home? ☐ Yes ☐ No

If so, do you get your carpets cleaned regulary? ☐ Yes ☐ No

If so, how often and by which company?____

Do you have a pet? ☐ Yes ☐ No

If so, descibe your pet? (kind, breed, size, etc) ____

Does your pet stay primarily outside or inside?____

What type of mattress do you have? ☐ Regular ☐ Pillow Top ☐ Water Bed ☐ Other:_____________

When was the last time you changed your mattress? _______________________________________

Do you use a plastic mattress cover? ☐ Yes ☐ No

What type of pillows do you have? ☐ Feather ☐ Synthetic ☐ Cotton ☐ Other:_____________

What type of comforter do you use? ____

Is the home air conditioned? ☐ Yes ☐ No

How old is your home? ____

Does your home have a basement? ☐ Yes ☐ No

If so, what is your basement used for? ____

Do you have moisture problems in your home? ☐ Yes ☐ No

Do you travel often? ☐ Yes ☐ No

If so, to where and for how long? ____

Notes:

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