endormir
SLEEP AND SINUS INSTITUTE

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Allergy Pre-Testing and Treatment Questionnaire

Name:_____ DOB:_____

This questionnaire is to improve patient safety for your allergy testing and/or allergen immunotherapy injection (allergy shots). Please review and answer the following questions. The nursing staff will review your responses and notify your physician if they have any questions or concerns about whether you should receive your testing or injection(s) today. **If you are pregnant or have been diagnosed with a new medical condition, please notify the staff.** (Please check the appropriate answer.)

1. Have you had increased asthma symptoms (chest tightness, increased cough, wheezing or shortness of breath) in the past week? [ ] **yes** [ ] **no**

2. Have you had increased allergy symptoms (itching eyes or nose, sneezing, runny nose, post-nasal drip or throat clearing) in the past week? [ ] **yes** [ ] **no**

3. Have you had a cold, respiratory tract infection or flu-like symptoms in the past two weeks? [ ] **yes** [ ] **no**

4. Did you have any problems such as increased allergy or asthma symptoms, hives or generalized itching within 12 hours of receiving your last injection, or swelling that persisted into the next day? [ ] **yes** [ ] **no**

5. Are you on any new medications? Please list:

6. Are you on any eye drops? [ ] **yes** [ ] **no**

Please list:

7. Are you or could you be pregnant? [ ] **yes** [ ] **no**

8. I brought my Epi-pen (adrenaline) with me today drops? [ ] **yes** [ ] **no**

Patient signature:_____ Date:_____

To be completed by office staff: